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VOL. I.—11TH YEAR.

SYDNEY: SATURDAY, APRIL 5, 1924.

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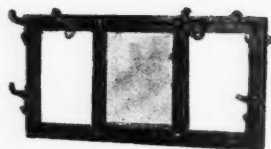
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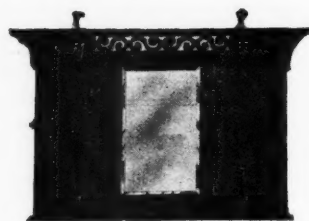
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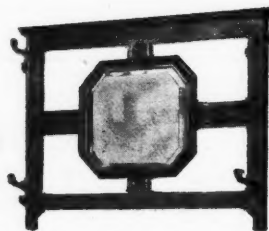
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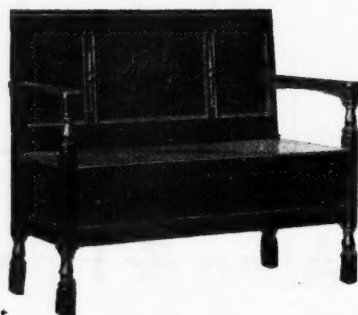
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An Address.¹

By C. H. E. LAWES, M.B., Ch.M. (Sydney),
Retiring President of the New South Wales Branch
of the British Medical Association.

THE subject of my address tonight is "The Evolution of the General Practitioner."

Previous to the seventeenth century the regular medical profession in England was divided into two classes, the physicians and the surgeons. Time will not permit of a detailed description of the development of these two classes, though the subject is one of great interest. I will, therefore, just briefly mention a few historical facts.

In 1511 an Act of Parliament was passed "to remedy the great inconvenience which did ensue by ignorant persons practising physic or surgery to the grievous hurt, damage and destruction of many of the King's liege people, most especially of them that cannot discern the uncunning from the cunning." It forbade anyone to practise as a physician or surgeon in the city of London and for seven miles around unless he had been first examined and approved by the Bishop of London or the Dean of St. Paul's, assisted by four doctors of physic.

In 1518 King Henry VIII. granted a charter of incorporation to the College or Commonalty of the Faculty of Physic in London. This charter was confirmed by a further Act of 1523 which gave the College authority to examine and license all physicians in England, except graduates in medicine of Oxford and Cambridge. It was not until 1851 that the College became the Royal College of Physicians of England. This title was confirmed in 1860.

In 1462 the large and prosperous Guild of Barbers became the Company of Barbers. The surgeons obtained a special charter in 1492 and in 1540 under Henry VIII. the Company of Barbers was united with the small and exclusive Guild of Surgeons to form the United Barber Surgeon Company. This company was to enjoy all the rights and privileges at any time granted to the two separate companies. Barbers, as such, were forbidden to perform any surgical operations, except the drawing of teeth, and surgeons were not to exercise the craft of barbering and shaving.

In 1543, "on account of the greed of surgeons, minding their own lucre and disdaining to help the poor," another act was passed permitting common persons having knowledge of herbal and folk medicine to minister to the indigent. By this Act unlicensed persons were allowed to treat outward sores and swellings with herbs, ointments, baths,

¹ Read at the Annual Meeting of the New South Wales Branch of the British Medical Association on March 27, 1924.

poultices and plasters and to give drinks for the stone, for strangury and for agues.

These unincorporated practitioners were the fore-runners of a third grade which now began to make its appearance in the medical profession, namely the apothecaries. These practitioners were given a charter by James I. in 1606, uniting them to the grocers, with whom they had long been associated. In 1617 the union was severed by a new charter and thenceforward the apothecaries were a distinct company or society. This new charter was granted for the sake of avoiding the abuses of unskilful and presumptuous empirics "who do make and compound many unwholesome, hurtful, deceitful, corrupt and dangerous medicines."

At this time, it is plain, the art of the apothecary did not include any right to treat disease. In order to protect the apothecaries' legitimate business, namely the sale of drugs, surgeons were allowed to apply only outward salves or medicine, but not to sell them. Thus surgeons were forbidden to sell medicines and grocers to keep apothecary shops. The apothecary's business had become a close corporation.

In passing I might mention some records of medical fees in the seventeenth century. These are interesting, but it must be remembered that the purchasing power of money was then seven or eight times what it is now.

The average fee of the English physician was about ten shillings and the annual salary of the professor of physic in the University of Cambridge in 1626 was forty pounds. An old bill of 1665 gives twelve shillings as the fee for a twenty-mile visit, another one pound, and for an outside visit of two days' duration thirty shillings. Bleeding a lady in bed cost ten shillings as against half a crown for a man. A *post mortem* examination cost three shillings and four pence. Thomas Arthur, an Irish physician, charged for the management of a case of gonorrhoea two pounds, paid in advance, and for a putrid sore throat eight shillings. An English surgeon's fee was twelve pence a mile, ten groats (a groat = four pence) for bone setting, one shilling for blood letting and five pounds for an amputation. The mediæval custom of paying a life annuity for a successful operation was still in vogue. Wiseman records an annuity of thirty pounds *per annum* from one patient. An army surgeon received six shillings and eight pence a day and a naval surgeon about six shillings and six pence a day.

The apothecaries came to the fore during the great plague of London in 1665, when they made good in public estimation by staying at their posts, while the physicians (even Sydenham) fled for their lives. During this terrible time the medical care of the sick poor fell largely into the hands of the apothecaries. This attendance of indigent persons was continued after the subsidence of the plague by the kindly, but poorly educated apothecaries, the "physicians of the poor," as one writer styles them.

Towards the end of the seventeenth century they were encroaching further and further upon the province of the physician. In order to resist this invasion of their rights the physicians in 1687 set

up dispensaries for the supply of medicines at cost price to the sick poor of London and its suburbs. The apothecaries considered this an attempt to undersell them and break up their monopoly of the drug trade. The long wrangle between physicians and apothecaries came to a head in 1699 by the publication of Garth's burlesque epic poem in six cantos, entitled "The Dispensary," the satire of which was aimed at the apothecaries. The poem had a great vogue and seven editions were printed in a year. Pope also had a slap at "modern 'pothecaries taught the art, by doctors' bills to play the doctor's part, bold in the practice of mistaken rules."

However, in spite of the support of men of letters, the physicians were finally beaten by the apothecaries. A test case was brought against an apothecary for exceeding his licence. This was first decided in the physicians' favour, but the decision was reversed on appeal to a higher court and it was laid down that the duty of an apothecary consisted, not only in compounding and dispensing, but also in directing and ordering the remedies employed in the treatment of disease.

After this the apothecaries went forward during the eighteenth century and became to all intents and purposes practitioners of medicine by right and not by favour.

Thus we see how the English apothecary by slow degrees and after various vicissitudes, fighting for his rights every inch of the way, became the fore-runner of the general practitioner of medicine of the present day. In 1815 the *Apothecaries Act* was passed which gave the society the right to examine candidates and secured a minimum qualification in medicine for the general practitioner. For sixty years or more the licence of the society, the L.S.A. qualification, was the most popular way of entering the medical profession in England and Wales and it was not until 1858 that a comprehensive *Medical Act* was passed and a general council of medical education and registration set up for the three kingdoms. It is said that between 1815 and 1883 the L.S.A. qualification was issued to nearly thirty-one thousand persons. Since the *Amending Act* of 1907 the registrable qualification has been altered to the L.M.S.S.A., London, signifying a licentiate in medicine and surgery of the Society of Apothecaries, London.

Having thus briefly sketched the evolution of the general practitioner up to modern times, it may be profitable to take stock and see where he stands to-day in the medical profession and what his prospects are for the future.

The medical profession may be likened to an army, its enemy being disease and sickness in all their forms. Of this army the general practitioner is and always must be the backbone; just as the infantryman is the backbone of a combatant army. The different divisions of the medical profession all have their uses and give invaluable assistance.

In a fanciful way the surgeons may be likened to the cavalry of an army, ever prepared to hasten hither and thither to grapple with sudden emer-

gencies, their weapons of steel always ready for use. The physicians might be compared with the artillery. They pour a continuous fire of pills and potions with bombs of serums and vaccines at the advancing foe. Eye and ear specialists correspond to the air force, launching counter attacks at those agencies which threaten the sight and hearing of our charges. X-ray specialists have their counterpart in the signallers, giving us information regarding the unseen work of our enemy. Public health and venereal specialists resemble our Army Medical Corps, their function being largely to prevent the enemy gaining a foothold, and if he does do so, to render first aid. The gynaecologists are in charge of the lines of communication and the obstetricians are the engineers who ensure safe roads for new arrivals. But all these branches of the medical army would be of no avail without the general practitioner, just as the branches of the combatant army would be useless without the good old foot-slogger, the infantryman. Therefore, I urge the general practitioner not to be downcast when he is feeling tired and worn out with the heat and burden of the day. His is an honourable and indeed an indispensable branch of the medical profession. In the past the general practitioner, the family doctor, has held a unique position in the community. He has been the family friend, the confidant of secrets, the lay confessor regardless of creed. When other visitors are expected the house is prepared for their reception, but the doctor goes into the bedroom at all hours and under all sorts of conditions. What he sees often surprises him, but to his credit be it said he seldom lets it be known. At the present time the position of the general practitioner is changing and the kind of family doctor who flourished in the last century is now thought to be old-fashioned.

Various innovations tend to intrude into the sphere of family practice. Of these the two most important are public health administration by the State and the provision of public medical aid by hospitals and dispensaries. In both of these spheres, however, the general practitioner should play an important part. In any system of preventive medicine the general practitioner must be the outpost, as it is under his notice that most cases of preventable disease come in the first place. In hospital work in all but the largest metropolitan hospitals the general practitioner should take his place, doing work on the honorary medical staff and in many cases on the committee.

To my mind one proposal which threatens the happy personal relations which have existed so long between the general practitioner and his patients, is that of national insurance. If this comes into force in this country, general practice among the wage earning classes will become a form of part-time civil service and the bulk of general practitioners will be under the discipline of a new statutory body, the Insurance Commissioners. In Australia I do not feel convinced that it is necessary and I believe that the bulk of general practitioners are of the same opinion. I think it will be a bad thing for the community, if the old position which the general practitioner has held so long, namely

that of family friend as well as physician, is done away with.

I would urge all general practitioners to strive earnestly to keep abreast of the times by making themselves familiar with the latest ideas and methods of treatment in medicine. It is impossible for the general practitioner to know everything, but with the help of his colleagues, the specialists in all branches, he should be able to maintain his place in the profession with dignity and honour to himself and with benefit to the community. Pope says:

A wise physician, skill'd our wounds to heal,
Is more than armies to the public weal.

Let it be our ambition to prove that this is so. In conclusion I cannot better end this address than by quoting to you the words of Robert Louis Stevenson when writing of the physician:

Generosity he has, such as is possible to those who practise an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments and what are more important, Herculean cheerfulness and courage. So it is, that he brings air and cheer into the sick room, and often enough, though not so often as he wishes, brings healing.

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DIFFUSE SCLERODERMA: WITH A CLINICAL ACCOUNT OF TWO CASES.

By A. HOLMES & COURT, M.D. (Sydney),
M.R.C.P. (London),
Honorary Physician, Sydney Hospital.

DIFFUSE scleroderma (or "sclerodermia" as it has more recently been described) is a rare disease. In the earlier medical writings it received recognition as a definite clinical entity under the name of "the hide-bound disease"—a not inapt term.

Various hypotheses have been advanced in regard to the ætiological basis. Of these three have received most support. It has been suggested: (i.) That the disease is of the nature of angio-tropho-neurosis, (ii.) that it is a result of endocrine disturbance, (iii.) that a terminal endarteritis with resulting interstitial inflammation is the anatomical basis. In the few instances in which *post mortem* findings have been recorded, the important changes have been extensive arterio-sclerosis with definite thickening of the walls of the small vessels. The peripheral nerves have shown thickening of the connective tissue sheaths, but no alteration of the nerve fibres themselves. The skin and subcutaneous tissues have presented constant changes, sclerosis of the smaller arteries often leading to obliteration. The elastic fibres beneath the papillary layer have shown considerable increase with extension into the subcutaneous tissues. Connective tissue in coarse homogeneous bands running parallel with the surface of the skin has been constantly present, sometimes forming a hard dense layer three to four millimetres in thickness. Whether these lesions are

primary, the results of inflammatory change, or secondary to undiscovered lesions of the nervous system, is a question which remains unsettled.

Three modes of onset of the disease have been described: Simple atrophic, œdematous, erythematous. In the latter two types arthritis or other manifestation of bacterial infection is not uncommonly observed, associated with the onset of the illness. Once established the disease may be progressive, lead to atrophy of the skin with deposition of fibrous tissue in the subcuticular tissues and result in extreme cases in almost absolute immobility so that the body finally resembles a frozen corpse or a mummy without power of movement save in eyes and tongue. The disease may, however, remain stationary for a long period and cases have been observed in which apparent remission has occurred. Pigmentary changes in the skin frequently appear, producing a parchment brown appearance accompanied by areas of leukoderma. Trophic ulceration of the hands, more rarely of the feet, may follow.

A remarkable deformity of the hand known as sclerodactylia may result. This is well demonstrated in one of the patients figured on page 336.

The diagnosis of the œdematous and erythematous types of scleroderma offers little difficulty, if the disease has once been observed. The predilection for the "cuirass" area, face, neck, upper limbs and thorax, is usually a characteristic of the diffuse type. In certain instances when the limbs are chiefly affected the possible co-existence of Raynaud's disease may lead to confusion. In the atrophic type, especially when associated with sclerodactylia and trophic ulceration, syringomyelia and leprosy have to be differentiated. The condition described by Gowers as local panatrophism has also to be borne in mind.

The absence of gross sensory change and peripheral nerve thickening with absence of bacteriological findings and the presence of well-marked bands of subcuticular fibrous tissue serve to establish the diagnosis. The peculiar tense feel of the skin which has been likened to that of a bladder of lard, together with the fact that folds of the skin cannot be picked up between finger and thumb, is characteristic of the condition. The two patients described herewith are of particular interest in that the characteristic features of the œdematous-erythematous type in the female patient contrast vividly with the atrophic changes leading to sclerodactylia and ulceration in the male.

Case I.—A female patient, *ætatis* forty-one years, was admitted to hospital on September 17, 1923. The patient was of a short obese type. The right foot had been amputated at the ankle in 1901 on account of tuberculous disease of bone. In 1919 she had suffered from pain and stiffness of the neck which had persisted for three months and which she likened to the onset of the present illness. After this she was apparently well until the onset of an acute febrile illness called "influenza" and associated with pain in left knee and ankle. This occurred two months prior to admission to hospital. The articular pain persisted and was accompanied by pain in the back of the neck and both arms. Tightness of the skin of face, neck and both arms with peculiar doughy swelling was then observed.

On examination the skin of face, neck, arms and the upper part of the thorax was found to be tense and hard. Folds of skin could not be picked up in these areas. Tenderness over the dorsum of left foot and about left knee was observed. There was a daily minor elevation of temperature to about 37.5° C. (99.5° F.). Blood count showed the red cells to number 3,350,000 and the leucocytes 6,200 per cubic millimetre. No reaction was obtained to Wassermann test. Radiographic examination of the skull revealed no abnormality. The diagnosis of diffuse scleroderma of œdematous or erythematous type was confirmed by several members of the hospital staff and treatment by daily doses of one gramme (fifteen grains) of thyroid substance was instituted. The disease appeared to progress for several weeks, the restriction of respiratory movement sometimes causing embarrassed breathing. Slight amelioration appeared after two months in hospital and the patient was discharged on November 20, 1923. The condition appeared unaltered six weeks later.

The accompanying illustration (see page 335) shows the mask-like immobility of the face and the restriction of movement of the arm.

Case II.—A male patient, *ætatis* fifty-three years, was admitted to hospital on October 11, 1923. The previous history was irrelevant except that patient stated that in 1907 he had suffered from "a swelling and itching all over the body which lasted for three years and then gradually disappeared." In May, 1920, the fourth toe of his left foot became red, swollen and painful; later it became tense and blue with throbbing pain. The patient opened the toe himself and later it "shrivelled up" and finally healed after several weeks. In January, 1922, the distal portion of the index finger of the right hand began to throb with shooting pain up the arm. The finger became blue and finally black and sloughing occurred; finally healing took place with some loss of tissue of the end of the digit. At this time the patient was admitted to a hospital where he was regarded as the subject of Raynaud's disease. He began to notice that he could not close either hand tightly and all the fingers became stiff and flexed at the distal interphalangeal joints.

In July, 1923, the ball of the right great toe became painful and finally ulcerated. This was followed by a similar affection of the left foot. This ulceration had persisted. On admission the patient stated that he felt "tight all over" and that the tightness appeared to be "inside the skin." He "could not stretch his arms or legs as he used to." He complained of stiffness of the neck and that swallowing was difficult so that water had to be taken with solid food. He was breathless on exertion and the feet and ankles tended to swell at night.

On examination the skin of head and thorax was darkened in colour and felt smooth, tight and indurated. The subcutaneous tissues failed to move freely over the subjacent muscles and the range of movement of the upper limbs was restricted by dense bands of fibrous tissue which could be seen and felt running in a ribbon-like manner along the anterior aspect of the limbs and across the anterior axillary folds. The hands showed remarkable changes; the fingers were stiff and flexed and the hand felt waxy and stiff like that of a frozen corpse. Peri-onychial ulceration was present on the fourth finger of the right hand. Both feet showed cyanotic induration and trophic ulceration on the soles.

Radiographic examination revealed absorption of the terminal phalanges of the thumb and index finger of both hands. Bones of both feet showed atrophic changes.

Repeated pathological examinations of material from the ulcers and nasal swabbings failed to show evidence of *Bacillus lepræ*. Blood examination revealed the red cells to number 3,560,000 and the leucocytes 7,500 per cubic millimetre. No reaction occurred to the Wassermann test.

The patient was afebrile and presented no evidence of other gross organic disease. He was discharged from hospital unchanged on November 22, 1923.

The accompanying illustrations (see pages 335 and 336) serve to demonstrate to some degree the appearance of these two patients.

In the first case little doubt existed in regard to the diagnosis as the nature of the changes in the skin and subcutaneous tissues was unmistakable. In the atrophic case the trophic ulceration and atrophy of the phalanges raised the possibility of *lepra mutilans*. The absence of pathological findings, the absence of anæsthesia and peripheral nerve thickening, associated with the sclerotic changes in the skin and fibrous tissue bands would appear to have established definitely the diagnosis of atrophic scleroderma with sclerodactylia. The deformity of the hands and feet, with the obvious ribbon-like bands of fibrous tissue in the arms can be observed in the photographs.

Acknowledgment.

The writer is indebted to Dr. Langloh Johnston, of the Dermatological Department of the Sydney Hospital, who confirmed the diagnosis in these cases.

EDWARD VI.

By C. MACLAURIN, M.B., C.M., F.R.C.S.E.,
Sydney.

THIS poor little boy in whom all the tragedy of the Tudors seems to have concentrated itself, was born to Henry VIII. and Queen Jane Seymour in 1537. Henry had already forgiven himself for his conduct to Anne Boleyn and was deeply attached to his new queen; during the progress of the christening he sat by the side of his wife and held her hand in order that she might not be too exhausted by the strain. She, poor thing, had to wear a great gown of ermine and to sit upright on a State pallet to welcome and bless her little son as the service terminated. But her loving arms could not save him; already within him were implanted the seeds of death, a tuberculous tendency from his grandfather Henry VII. and actual spirochætes from his father Henry VIII. And, as Queen Jane clutched him to her bosom, she herself began to shiver; no doubt she thought her shivering was from fear lest she lose her son; but within a week of his birth she lay dead, probably from puerperal septicæmia. Henry was heart-broken; but at least the curse of the Church had been lifted: he could now honestly say that he had begotten a living son and that the succession of the English throne was safe. Where the brilliant and charming little Anne Boleyn had failed, this commonplace and featureless Queen Jane, so colourless that everybody liked her or at least did not hate her, had succeeded. So, she being dead, Henry discreetly communicated with the Court of France in order to get him another wife, if possible, that the Church might see how impotent it was to affect human destiny. This was not because he was incurably lustful, but because it was still important to have another heir, should little Edward turn sick and die. Already, one thinks, the English Prometheus was scaling Olympus with determined, though engrossed footsteps; already the Church of Rome might well tremble at the ponderous footfalls of this fat and syphilitic man.

But little Edward did not seem likely to die; for to all appearances he was a strong and healthy little

boy. If the Court of England had purposely meant to deny that Edward was syphilitic, it could not have chosen better words to do it in, for, as the message announcing the glad news of his progress said: "He sucketh like a child of *puissance*." In the typical infantile hereditary syphilis the baby suffers from "snuffles" and its sucking powers are, to say the least, inadequate. But the spirochæte has other ways of taking its revenge upon its host. It may lie latent for years and so poison the child's resisting powers that he falls an easy victim to some other deadly bacterium. In the case of little Edward it seems to have been the tubercle bacillus that seized upon its chance; and when fifteen years later during the "storms of puberty" it was working its deadly will upon him, the spirochæte of syphilis joined the assault, as we shall see.

Edward was an affectionate little boy, of good impulses. Of course it was unthinkable that a prince should ever be flogged; so the fond father appointed a whipping-boy to act vicariously in his stead. It was Barnaby Fitzpatrick who was honoured by receiving the royal thrashings, though Edward was such a good little boy that Barnaby was seldom called upon for duty, but grew up a firm friend of the little king who might have suffered in his person but for him. Edward's wet-nurse was a motherly woman whom he later called his "mother-jak." I do not know what childish utterance that may have represented, but it is silly enough a term to have come from the mouths of babes and sucklings. At eleven months old no less a personage than Thomas Cromwell visited him officially and, no doubt, dandled him upon his knee. Says Cromwell's secretary, speaking of this time: "And I do assure your lordship that I never saw so goodly a child of his age; so merry, so pleasant, so good and loving a countenance and so earnest an eye, as it were exercising a judgement towards every person who repairth to his grace; and, as it seemeth to me, his grace encreaseth well in the air where he is." Already he had been sent to the country for his health. "And, albeit a little of his grace's flesh decayeth, yet he shooteth out in length and waxeth firm and stiff and he can steadfastly stand." So clearly he was a nice little boy of eleven months, if anything rather forward for his age.

When he was about two, his father, the King, used to take his little son in his arms and stand at the window to show the multitude how bravely his boy was fighting life; and the crowd would clap and cheer for joy, for King Henry VIII. was still the most beloved of men and the Tudor succession was at every Englishman's heart; the awful degeneration in the King was still to come and there is no more delightful scene in Henry VIII.'s life than that of him standing at the window holding up his son to be cheered by the crowd. How little we really know of our public men! Who could have foretold that this smiling King was to become the most murderous tyrant who ever sat upon the throne of England? For the present let him be glad and his little son with him, smiling and

chuckling with true Tudor tact. The tragedy to both comes soon enough.

Some time before this the proud wet-nurse announced that her foster-child "has three teeth and a fourth appeareth." I cannot discover the exact age at which this announcement was made. It would be interesting to know whether his dentition was entirely normal; but probably little Edward seemed normal enough, except for his brains. When he came to be educated the amount of learning that was stuffed into that poor child's head was simply amazing—worthy of Elizabeth; worthy of bluff King Hal himself. He could speak both Latin and Greek; he habitually wrote in Latin and could translate a Latin author into Attic Greek. For his friend he selected little Jane Dormer, a girl of his own age; the two ran about and played together, though Janey could never equal Edward's brilliance. The two made a pretty picture, if you can forget the fate that was hanging over the little boy. He kept a journal and a day came when he noted: "This day I fell sick of the measles and the small-pox." The young diagnostician must have been very sure of his insight. The fact that two dissimilar eruptions came out on the little boy at the same time rather seems to indicate that there was some other toxin at work.

As he grew up he began to show signs of both obstinacy and religiosity, which with a little encouragement might have become as fanatic as Mary Tudor's herself and led to real good old sixteenth century religious persecution. It was perhaps fortunate for England that the clever little boy died before he could do any more mischief. We know a great deal about his actual death. For a long time he health had been failing; he was racked with a constant and incurable cough and apparently showed all the symptoms of a rapid consumption. The regular doctors having failed to cure him, England's Majesty was entrusted to the care of a woman who professed to have acquired possession of a cure-all. Under her treatment the King became rapidly worse. "His legs swelled, his complexion became sallow, his hair fell out; the terminal joints of his fingers fell off" (Syphilitic dactylitis?). "Eruptions came out on his skin and he lost his nails and afterwards the joints of his toes and his fingers." The luckless laundress who washed his shirts, also suffered from terrible things; she lost her nails and the skin off her fingers, which gave rise to the suspicion that someone had been trying to poison the King, her employer. But probably either she had been using some crude soap or else she had syphilis herself. So, the quack having proved that her cure-all was doing the King more harm than good, was sent about her business and the regular doctors were recalled. Froude thought that she had been using some mineral poison and that in truth Edward VI had actually been poisoned by her, though not intentionally. As for me, I am quite prepared to believe that she had somehow got hold of a preparation of mercury which she was using on the light-hearted assumption that in 1550 everybody was suffering from syphilis and that

when she tried it on Edward's form, already wasted and powerless by the long struggle with tuberculosis, the spirochaetes that had been lying latent within him, suddenly became active with the terrifying results we have just seen. Possibly the woman may have bragged of her discovery about mercury; and everybody would at once say: "See what you are doing to our beloved young King with your mineral poisons!" There is much virtue in a name. Call mercury a "mineral poison" and it is at once damned as much as if you had called it a "drug." But vegetable poisons are far worse than mineral poisons; yet nobody dreams of saying that we should not take strychnine to "buck us up" nor "morphine to relieve us of intolerable pain." Probably it was that woman's hard luck that she tried mercury at the very moment when the King's latent syphilis was beginning to come to the surface; and no doubt it was just such incidents as this which have given to mercury such a bad name, that the moment one prescribes it, the patient always says: "Not mercury, doctor, please!"

But that unfortunate woman was dismissed and the regular practitioners returned to their prey with the good old sixteenth century remedies for coughs, which, if they could not cure, would certainly not bring the patient all out in a rash. The rumour went about that they were poisoning the King—that he was already dead. As young Edward lay gasping and coughing and sweating on his death-bed his attendants said to him that it would be wise for him to let himself be seen; so, with true Tudor sense of duty he dragged himself to the window and looked out at the crowd waiting like ghouls to hear that he was dead. When they saw his face, grey, pinched and dying, the crowd cheered as it had cheered when it saw him held up in his father's arms. Though some cheered, yet some held to it that a boy who could look so ghastly must be dead and indeed the rumour that he was dead was but confirmed by the sight of him.

His last prayer was: "O Lord God, free me, I beseech you, from this calamitous life!" What was that poor young lad doing that he had already begun to wonder why he had ever been born, as many men have wondered since him? Tuberculosis of the lungs is often accompanied by a sense of euphoria, that is to say, the patient does not feel so ill as he should feel. But syphilis of the lung is gloomy enough and sometimes gives rise to symptoms indistinguishable from tuberculosis. Then, after he had been trying to look upon his subjects with eyes that probably saw nothing, he suddenly cried: "I faint; Lord, receive my soul!" and fell back dead.

Probably it was lucky for him and lucky for England that he died; even though before sanity was to come to England with Elizabeth, the people had to pass through the bad health and religious persecution of Mary Tudor. Had Edward VI. lived, he would probably have been just as dangerous. *Sed dis aliter visum.*

THE LIVING SUTURE IN TENDON TRANSPLANTATION.

By N. D. ROYLE, M.B. (Sydney),
 Honorary Orthopaedic Surgeon to the Lewisham
 Hospital; Honorary Orthopaedic Surgeon
 to the State Children's Relief Board.

THE fixation of transplanted tendons in new positions always presents a difficulty and very disappointing results sometimes follow the most careful suturing with ordinary suture material. Even when a transplanted tendon is passed through a tunnel in bone, the difficulties are not always ended since the transplanted tendon has still to be anchored adequately until fixation occurs in the new position. The occasional peculiar behaviour of both silk and catgut when passed through living tendons led me to undertake a number of experiments in which various suture materials were placed in the *tendo Achillis* of rabbits. Catgut of various sizes, kangaroo tendon, silk, horsehair and fishing gut were used. Most of these materials set up an inflammatory reaction in the tendon, but by far the greatest appeared to occur in the presence of catgut. In some instances the suture material appeared to be undergoing a liquifying process which involved the surrounding tissues of the tendon also. Silk gave rise to a similar reaction, but not as great as that in the case of catgut. Kangaroo tendon resisted the liquifying process to a much greater extent than catgut, but there was also round each stitch hole a definite softening of the tendinous structure. Horse hair and fishing gut gave rise to practically no inflammatory reaction at all. It was quite evident in examining the results of these experiments that the failure in some instances of tendon transplantation could be attributed to the cutting out of stitches in the liquifying process and to the weakening of the transplanted tendon at the insertion of each stitch. While these experiments were in progress Gallie and Le Mesurier⁽¹⁾ reported their clinical and experimental observations in the transplantation of fascia and tendon and I immediately tried the effect of passing living sutures of tendon

through the *tendo Achillis*. At the end of fourteen days there was very little inflammatory reaction with no evidence of a liquifying process where one tendon had been passed through the other and the tendon which had been used as a stitch, appeared to be alive and healthy.

On these results a technique was devised for using a living suture in tendon transplantation. For example, should it be necessary to transfer one of the peroneal muscles into the position of the *tibialis anterior*, the peroneal muscle is freed from its attachment and introduced into the sheath of the *tibialis anterior* above the ankle joint. Its tendon is then stitched to a special flexible probe which has been introduced into the sheath of the *tibialis anterior* through an incision over its insertion and made to

appear in the wound above the ankle joint (see Figure I.).

The peroneal tendon can then be drawn through the sheath of the *tibialis anterior* and the probe is re-introduced and made to appear again in the wound above the ankle joint. One-third to one-half of the tendon of the defective *tibialis anterior* muscle can then be freed and stitched to the probe. Withdrawing the probe once again from the sheath of the *tibialis anterior* this section of tendon strips itself from the main tendon and can be drawn out of the incision at the insertion of the *tibialis anterior* to act as a living suture. Its distal end retains its original insertion. The raw surface left by stripping this piece of tendon does not interfere in the least with the gliding mechanism of the



FIGURE I.
 Showing the Flexible Probe Introduced into the Sheath
 of the *Tibialis Anterior* to Bring Down the Piece of
 Tendon Forming the Living Suture.

sheath. The length of this suture varies with the point of section above the ankle joint, but it is easy to obtain a living suture at least twenty centimetres long in the adult subject. The diameter of such a suture may be three millimetres, but, if compressed in one direction, it can be made to go through the eye of a large fistula needle. The transplanted tendon is then roughened on the surface, drawn through a slit in the recipient tendon and with the living suture the two tendons are woven together.

A similar technique can be employed in transplanting peroneal muscles and the *tibialis posterior*

backwards to reinforce a defective gastrocnemius and soleus. The transplanted tendons are introduced into the *tendo Achillis*. A very satisfactory living suture can be obtained from the *tendo Achillis* itself and with this all the transplanted tendons and the recipient tendon can be woven into one compact mass. Small tendons such as those of the long extensors of the toes may be threaded on a needle and sewn directly on to a new attachment.

This principle of tendon fixation can be employed wherever a healthy muscle is being transplanted to replace a defective one and in most instances the recipient tendon can be made into the living suture. The advantages of the method are: (i.) An organic union occurs between the recipient and the transplanted tendon not only on account of the apposition of raw surfaces, but also by being transfixed in numerous places by a piece of living material of similar nature; (ii.) there is no dead material to be absorbed or extruded; (iii.) the living suture retains its original insertion and ensures a fixed attachment for the transplanted tendon; (iv.) the transplanted tendon is firm in its position much sooner than when dead material is used.

This fact was exemplified in the first patient on whom the method was tried. Three weeks after an operation in which the *peroneus longus* was transplanted into the position of the *tibialis anterior* the patient was brought back to hospital with the plaster of Paris casing very much broken and he admitted that he had been walking about on the foot. Contrary to expectations the *peroneus longus* had not slipped in the least in its new attachment and the patient had acquired the power to dorsiflex the foot with it in its new position. This power has been retained.

In a number of subsequent operations consistent results have been obtained and in no instance has there been any evidence of lengthening or slipping of the transplanted tendons. The method has been in use for over eighteen months.

Reference.

¹ W. E. Gallie and A. B. le Mesurier: "A Clinical and Experimental Study of the Free Transplantation of Fascia and Tendon," *The Journal of Bone and Joint Surgery*, July, 1922, page 600.

DIRECT SMEARS.

By H. O. LETHBRIDGE, M.B.E., M.B., Ch.M. (Sydney),
Narrandera, New South Wales.

THE great value of microscopical examination of direct smears of all sore throats is too little appreciated, particularly in the country. The posting of a swabbing to be smeared after a perilous passage of many hours on a serum tube and incubated is useless, because it is quite unreliable and because the patient needs the opinion at once, not next day. At the Children's Hospital, Sydney, the worry of diphtheria occurring in the general wards soon brought home to me the benefit of immediate diagnosis when possible by direct smear. Since then I have always examined about 95% of all sore throats that come to me in practice. In addition to this,

last year I examined some nine hundred smears from throats of school children in an endeavour to check the diphtheria which had been too prevalent in this town. Since this there has been practically no diphtheria in school children here, although it will probably recur sooner or later.

Direct smears may for practical purposes be divided into three categories: (i.) Those in which within one minute numbers of definite granular Klebs-Löffler bacilli are seen—definite diagnosis of diphtheria; (ii.) those in which a rapid examination of the slide reveals staphylococci and kindred organisms and in which no bacilli are evident—definite exclusion of diphtheria; (iii.) those wherein the



FIGURE II.
Showing the *Tibialis Anterior* and the *Peroneus Longus* Woven Together with the Living Suture. The Suture is still in Position.

field reveals fusiform bacilli, spirilla and many diverse organisms.

It is this third class which is difficult and takes time. Usually, however, at the end of five minutes an opinion can be formed whether or not Klebs-Löffler bacilli are present.

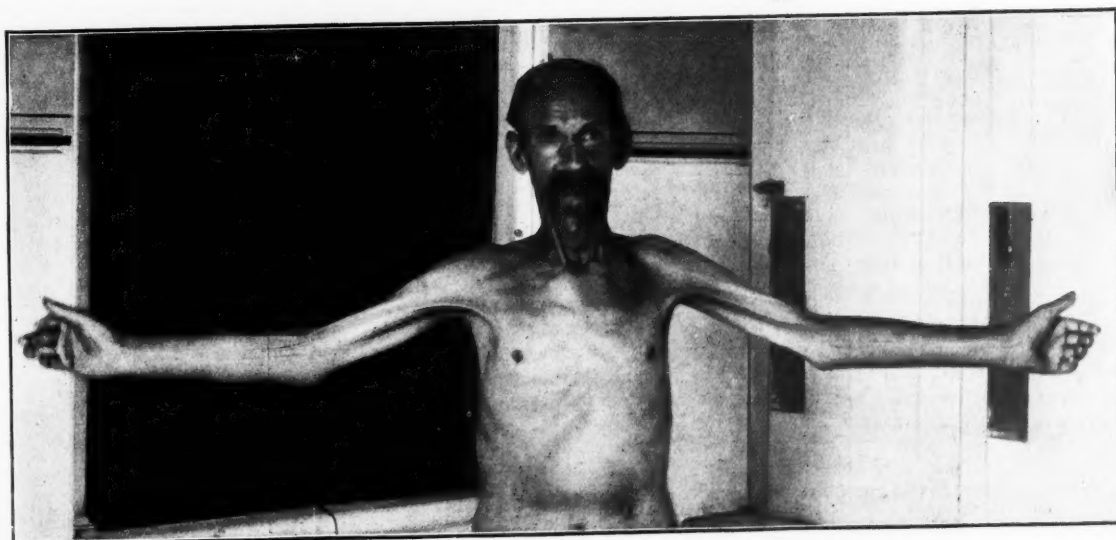
It must be admitted that the organism which will grow in the tube, must equally well be placed on the slide. Why wait to look at the children when one can look at once at dad? Both Löffler's blue and toluidin are good stains for this work.

It is found that in different epidemics of "sore throat," different organisms prevail. It is usually possible to pick out the causative organism. Rightly

ILLUSTRATIONS TO DR. A. W. HOLMES A COURT'S ARTICLE.



CASE I.—Diffuse Scleroderma.

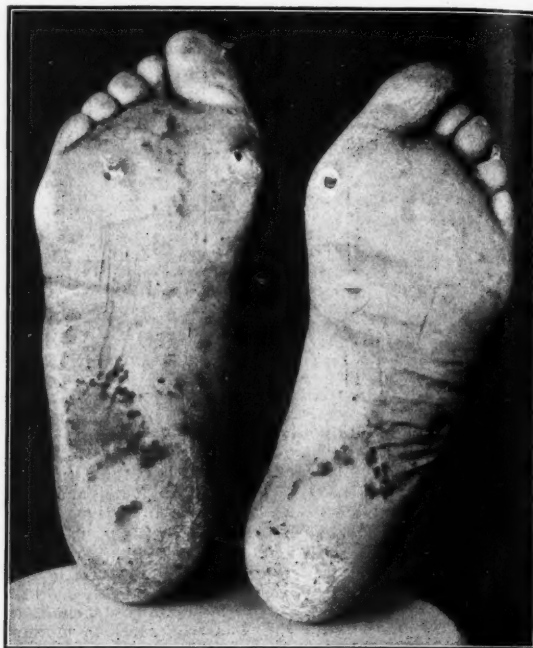


CASE II.—Atrophic Type showing Fibrous Tissue Contractures.

ILLUSTRATIONS TO DR. A. W. HOLMES & COURT'S ARTICLE—(Continued).



CASE II.—Sclerodactylia.



CASE II.—Trophic Ulceration of Feet.

ILLUSTRATION TO DR. G. R. HAMILTON'S ARTICLE.

Figure showing Pringle Type of *Adenoma Sebaceum*.

or wrongly, the preponderance of one particular organism, especially if this organism appears in clumps or masses and stains readily, seems to justify the conclusion that this germ is probably the main cause of the trouble. Often, too, the knowledge gained by this examination is of great importance in relation to treatment.

Reports of Cases.

ADENOMA SEBACEUM.

By G. R. HAMILTON, M.B., Ch.M. (Sydney),
Honorary Dermatologist, Royal North Shore Hospital,
Honorary Assistant Dermatologist,
Sydney Hospital.

ADENOMA SEBACEUM is a rare congenital affection of the skin, characterized by an overgrowth of the sebaceous glands, seated usually on the face, but occasionally on other parts of the body. Sometimes the sweat glands and the hair follicles are involved. Three types have been described: (i.) Pringle⁽¹⁾ type in which the tumours are pink or red—a glandular and vascular hyperplasia; (ii.) Balzer type, in which the lesions are pale and the sebaceous glands undergo an atypical proliferation; (iii.) Hallopeau and Leredde type, in which there is a predominance of fibrous tissue.

The cause is unknown. It usually begins at birth and is often associated with other congenital anomalies. The majority of cases have been seen in mentally deficient or epileptic children.⁽²⁾ Sequeira⁽³⁾ has seen cases in mother and daughter and Adamson⁽⁴⁾ in mother and son. Shelmire⁽⁵⁾ has reported five cases in one family and Taylor⁽⁶⁾ has seen three cases in one family, while Klauder⁽⁷⁾ reports its occurrence in a patient whose father, uncle and brother were affected. The patient whose condition I am reporting, has an interesting family history in that the grandmother (on her mother's side), her mother, one maternal aunt, like herself all have the affection and all are mentally deficient.

The girl illustrated on page 336 first consulted me when she was seventeen years old and her condition is an example of the Pringle type of *adenoma sebaceum*. She had had the affection since birth, is mentally deficient and subject to epileptic fits. The clinical features in her case showed that the papules affected the middle third of the face and the chin, but not the forehead. In size they varied from a pin's head to three millimetres in diameter. The majority of the lesions were pink in colour, but scattered

amongst them were some larger bright crimson little nodules, as can be well seen in the photograph. The general distribution was very symmetrical.

She also had on her back in the mid line just above the sacral cleft a group of little colourless tumours. The only other congenital anomaly I could find was a colourless linear naevus on her back on the left side.

In regard to treatment excision and electrolysis have been recommended. My only experience has been the use of electrolysis on a patient at the London Hospital under my late chief, Dr. J. H. Sequeira. The result was most disappointing.

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- ⁽¹⁾ J. J. Pringle: *The British Journal of Dermatology*, 1890, page 1.
- ⁽²⁾ H. Radcliffe Crocker: "Diseases of the Skin," Third Edition, Volume II., page 923.
- ⁽³⁾ J. H. Sequeira: "Diseases of the Skin," Third Edition, page 43.
- ⁽⁴⁾ H. G. Adamson: *The British Journal of Dermatology*, April, 1911, page 109.
- ⁽⁵⁾ J. B. Shelmire: Transactions of the Section of Dermatology, American Medical Association, 1918, page 141.
- ⁽⁶⁾ G. G. Stopford-Taylor and F. H. Barendt: *The British Journal of Dermatology*, 1893, page 360.
- ⁽⁷⁾ D. J. Klauder: *Archives of Dermatology and Syphilology*, June, 1923, page 849.

COMPLETE HEART BLOCK.

By E. W. FAIRFAX, M.B. (Sydney),
Honorary Physician, Royal Prince Alfred Hospital.

AND

W. N. HORSFALL, M.B., B.S. (Melbourne),
Sydney.

R.G., aged thirty-four years, a returned soldier, was admitted to Royal Prince Alfred Hospital on September 21, 1923, suffering from extreme breathlessness on exertion and pain in the præcordium. He had suffered from headaches for the last two and one-half years. Both his parents were dead, cause unknown. He has four brothers and one sister alive and healthy. He has two children, aged three years and one year respectively. He was born in Australia and lived here all his life excepting for a period of two years spent on active service. He is a bad sleeper.

History of Present Illness.

R.G. used to become giddy after severe exertion two years ago and later became very breathless and lost the power of his legs.

At this time he did not have pain over the præcordium. This pain began about eight months previously to his admission to hospital and had progressed till the time of his admission when the pain was continuous.

Condition on Admission.

The pain extends over the præcordium and into the right axilla. The pain is of a gripping, squeezing nature and when severe he has to be propped up in bed as he becomes very breathless. His appetite is good, the bowels are well open and he has no urinary symptoms.

Alimentary System.

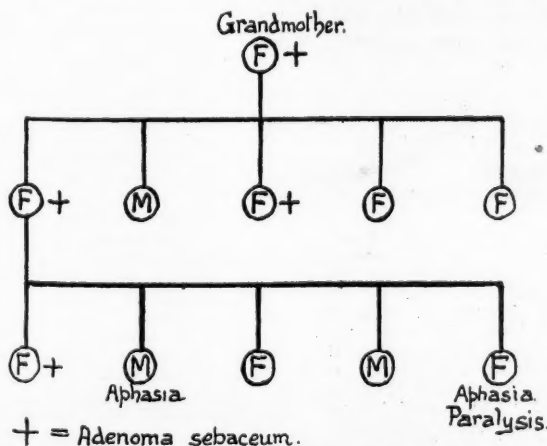
The tongue is clean and moist; teeth are good. The abdomen is full and soft. There is no tenderness or rigidity. Nothing abnormal is detected.

Respiratory System.

The chest wall is well developed. It moves evenly on respiration. The percussion note is resonant throughout. The breath sounds are normal with no accompaniments.

Genito-Urinary System.

The urine is acid; its specific gravity is 1015. It contains no albumin, no sugar and no pus.



Genealogical Tree of Dr. Hamilton's Patient.

Nervous System.

The pupils are large and equal. They react to light and accommodation. The knee jerks are present.

Circulatory System.

The upper border of cardiac dulness reaches to the third rib, its left border ten centimetres from the mid-sternal line. There is no dulness to the right of right sternal margin.

The apex beat is found ten centimetres from the mid-line in the fifth space.

The heart sounds are slow, thirty-two to thirty-eight and except for an occasional premature beat. The tone is good. There is a mitral systolic murmur conducted to the axilla.

The vessel walls are palpable; the pulse rate is slow, its tension is fair and its force and volume are average.

He was given 0.0006 gramme of atropine every four hours for twenty-four hours on two occasions. There was no influence on the heart rate. The serum does not react to the Wassermann test.

After the first fortnight in hospital dyspnoea and pain decreased. A week later the pain was less frequent, less severe and confined to the præcordial region. He was then allowed up, first on a chair, later walking. There were occasional attacks of dull pain under the sternum. The rate and character of the pulse did not change. Walking quietly thirty or thirty-five metres in the ward did not alter the pulse rate. Walking quickly caused the præcordial pain to return, but did not alter the pulse rate.

The curves all taken at the same sitting show a case of complete heart block. No impulses from the auricles are transmitted to the ventricles. Normally the sino-auricular node develops impulses seventy-two times a minute on an average. But there are other parts of the heart which have this property of rhythmicity. The sino-auricular node has it in a higher degree than other parts of the heart. The primitive tissue which represents the remains of the primitive cardiac tube and which is represented by the sino-auricular node, auriculo-ventricular node and bundles, has it to a higher degree than the later developed ventri-

cular muscle. We mean by a higher degree of rhythmicity that impulses can be developed at a quicker rate.

If by experiment the bundle is crushed, the ventricles begin to contract at their own rhythm which is at a slower rate. Some part below the crush controls the rhythm. Clinically in complete heart block the centre governing the rhythm of the ventricles is usually supra-ventricular in origin. That is the centre governing the rhythm is the auriculo-ventricular node or some part of the bundle above the division into its right and left

divisions. In these cases the ventricular complexes are of a normal character. In the case recorded this is not so. Figure I. shows the P waves indicating contraction of the auricles. The P waves space evenly throughout the curve excepting where they are lost in the ventricular complex.

The ventricular complexes are of two types. The first beat of each couplet is predominantly a right ventricular effect. The second beat is a left ventricular effect. They each have the character of extra systoles excepting the second beat in lead i. which is not diphasic in that T is upright.

These ventricular complexes have the characters of extra-systoles and they arise from the right and left ventricles below the division of the bundle into two branches. We know this because in the right ventricular complex the main deflection is downwards in lead i. and upwards in lead iii. The left ventricular complex is upwards in lead i. and downwards in lead iii. They are each diphasic in character. Compare lead ii. in Figure II. As the plate is running slower we see the two couples to better advantage.

Figure III. taken immediately after Figure II. shows different ventricular complexes. The couplet or bigeminy has disappeared. The heart rate is regular. Beats 2, 3 and 4 resemble each other. In this curve the sensitivity of the string was such that fifteen millimetres excursion equals three millivolts. Hence the excursions of the string are smaller than they otherwise would be. In the other curves the sensitivity was such that thirty millimetres equalled three millivolts.

Now it can be stated that there is not one definite site of impulse formation governing the ventricles. For a time

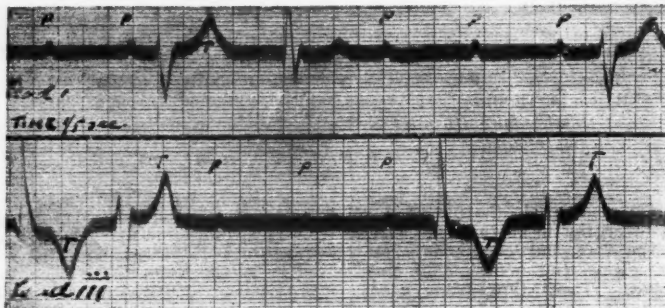


FIGURE I.

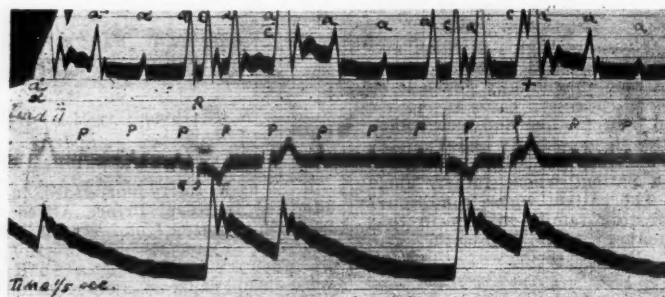


FIGURE II.

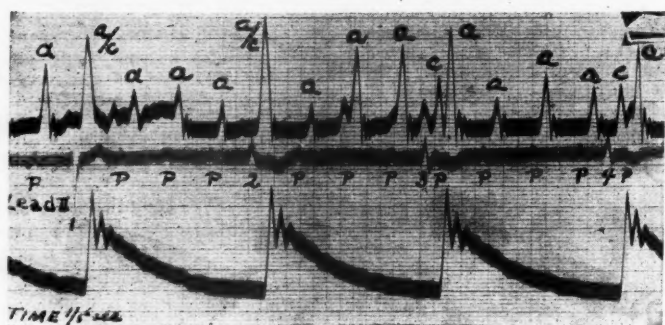


FIGURE III.

in Figures I. and II. two different rhythms are inaugurated, one in the right bundle or its branches or in the right ventricle in the inter-ventricular septum, the other in the left bundle or its branches or in the left ventricle in the inter-ventricular septum. The rate of these two rhythms would appear to be different as there is a varying interval between the two beats of each couplet in Figures I. and II. The ventricular rate is about thirty-four per minute in Figures I. and II. In these curves the rhythm of each centre would be about seventeen per minute. It is impossible, however, and wrong to base definite conclusions on such short stretches of curve.

In Figure III. the ventricular rate is about twenty-three per minute. The patient would be better off with the former rhythm in progress as in Figures I. and II. All three curves were taken within the space of fifteen minutes.

There is no doubt but that different parts of the bundle or its branches are striving for mastery of the rhythm of the ventricles. If a new beat arises, say in some part of the right ventricle, the impulse spreads through that ventricle by means of the Purkinje system of fibres at a rapid rate. The impulse then spreads to the left ventricle. There are two ways in which it may go. It may travel by slow muscular conduction through the inter-ventricular septum and then a small fraction of a second later involve the Purkinje system of the left ventricle; or it may travel up the right bundle to the division of the two bundles and then down the left bundle and through the Purkinje system to the left ventricle. In either case it causes the left ventricle to contract. The impulse chooses that path in which it can travel to the left ventricle in the shorter time.

So far we have discussed the electro-cardiographic curves. Figures II. and III. have an additional interest. They show lead II. of the electro-cardiogram taken simultaneously with the movements of the lever recorded by the polygraph. The upper curve is a tracing of the jugular pulse taken by placing a receiver over the region of the jugular bulb; the lower is an arterial tracing taken from the brachial artery. The writing levers of the polygraph are made to project in front of the camera. As the plate falls, their movements are thus recorded simultaneously as the galvanometer is inscribing lead II. Their time relations must, therefore, be accurate and definite. The curves of Figures II. and III. prove that polygraph tracings, though at times they may be perplexing, are definite records of definite events and do not require any imagination to make them intelligible.

The second beat of the bigeminy of the arterial curve in Figure II. is smaller than the first beat only for the reason that the ventricle has not had time enough to fill with blood after the preceding beat. Its systolic output is therefore less and the pulse volume is less also.

The jugular pulse shows equally spaced A waves which indicate auricular systoles.

The C waves which indicate the systolic output of the left ventricle, should first be demonstrated. They occur 0.1 second before the arterial pulse in the lowest curve. That is to say, there is a difference of 0.1 second in time between the pulse as recorded at the carotid artery, until it is found at the brachial artery at the bend of the elbow.

The A waves vary in height. This variation depends on two factors:

(i.) The degree of stasis of blood in the jugular veins, superior *vena cava* and right auricle. If the auricles contract when the entering veins are full of blood, the A wave must be more pronounced.

(ii.) The closure or otherwise of the tricuspid valve during auricular systole.

In Figure II. (top curve) the first auricular contraction coincides with c when the tricuspid valve was closed. Ventricular systole lasts approximately till the end of the T wave of the electro-cardiogram. The right auricle could not empty. The next A wave is large because of the great degree of stasis of blood. Then follows a small A wave. As stasis begins again to show itself, the next A wave is

larger. The fifth A wave is still large because the tricuspid valve is not yet open. It begins just before the end of T. The next beat shows A and C superimposed. Auricles and ventricles are contracting at the same time.

Further on in the curve indicated as X, A rises from the peak of C. The auricular rate is slightly more than eighty per minute.

Figure III. calls for no further comment. The curves throw light on the mechanism of the heart beat in the condition of complete heart block. The patient's condition shows us how dependent we are on our sino-auricular nodal rhythm for our various activities. These activities necessitate varying degrees of systolic output. This is in part determined by a rapid flexibility of cardiac rate. A flexibility of cardiac rate is not obtained when we lose the sino-auricular control over the ventricles.

The patient's heart rate alters but little on any activity. Hence his activity is limited. The action of the heart can be likened to the mechanism of a motor car in which there is only one set gear and in which there is no accelerator.

SECONDARY ANÆMIA PROBABLY DUE TO CONGENITAL SYPHILIS.

By H. BOYD GRAHAM, D.S.O., M.C., M.D.,
Medical Superintendent, Children's
Hospital, Melbourne.

M.M., a female, *ætatis* nine months, was admitted to the Children's Hospital, Carlton, Melbourne, on September 3, 1922, with broncho-pneumonia and extreme pallor.

Past History.

At birth, which occurred in the seventh month of pregnancy, her weight was 1.8 kilograms (four pounds); she had always been very pale and under-nourished. For two months she had been breast fed, but thereafter had been artificially fed with cows' milk dilutions. She had not shown any signs of florid syphilis.

Family History.

The mother and the father regarded themselves as healthy, though on investigation a definite Wassermann reaction was obtained with the serum of each. The two other children, aged five years and three years, looked healthy and their sera failed to yield the reaction. The third and fourth pregnancies terminated in the fourth and third month respectively.

Investigation.

She had signs of broncho-pneumonia of the right lung for three weeks after admission with intermittent temperature. Later, though the temperature was elevated on occasions in the evening, for the most part she was afebrile and the lung signs disappeared.

At the age of nine months and again at the age of eleven months her serum failed to yield the Wassermann reaction.

Hæmatological examinations showed the presence of severe anæmia of the secondary type.

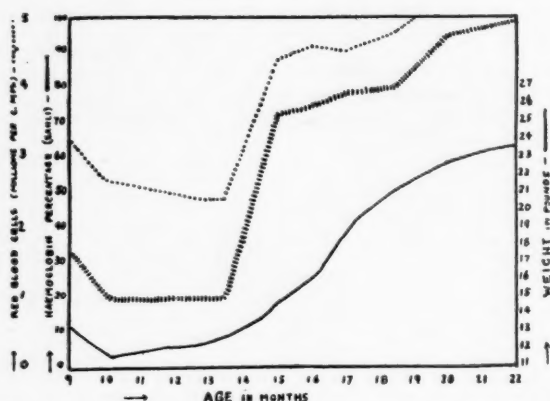
Radiographic investigations of the skull and long bones were carried out, but no positive findings were obtained.

Ophthalmoscopic examination revealed abnormal pallor of the fundi.

For several weeks the spleen was just palpable at the costal margin, but later it was not palpable.

Treatment.

At first the broncho-pneumonia received attention. Then a course of six deep subcutaneous injections of "Nov-arsenobillon," totalling 1.5 grammes, was administered with auxiliary mercurial treatment. When the baby was thirteen and a half months old, powders consisting of *ferri carbonas saccharata* 0.18 gramme (three grains) and *hydrar-*



pyrum cum creta 0.06 gramme (one grain), were given three times a day. Anti-syphilitic treatment had been discontinued for two months and no alterations were made in the dietary.

The graph shows that from the time the preparation of iron was exhibited, the hæmoglobin percentage, the red cell counts and the weight rapidly improved.

The powders were given regularly and, when the child was sixteen months old, the amount of carbonate of iron in each powder was increased to 0.3 gramme (five grains) and six weeks later a further increase to 0.36 gramme (six grains) was made.

The powders were discontinued when the child's age was twenty months. By this time, she looked the picture of health and her development was normal with the exceptions that she was somewhat under average weight and, though she was able to stand unsupported, she could not walk.

Comment.

The history of this patient shows the following points of interest:

- (1) The demonstration of the value of a preparation of iron in the condition of secondary anaemia.
- (2) The unusual family history in which, though the parents on serological grounds would appear to be untreated syphilitic subjects, their three children failed to give any evidence of infection, unless the secondary anaemia of the youngest child was due to syphilis.
- (3) As serological evidence of syphilis was not obtained before the use of a reliable arsenical preparation in adequate dosage, it is not available now to help us to decide whether the child is a congenital syphilitic.

Reviews.

SURGERY OF THE RECTUM AND COLON.

LOCKHART-MUMMERY has combined his previous works on the colon and on the rectum into one volume and called it "Diseases of the Rectum and Colon."

There is no doubt, as Mummery remarks, that diseases of the large bowel are becoming more common and that this is probably due to the modern methods of dietary. Hence the surgery of this region is becoming increasingly important.

The author reviews extensively the physiology and bacteriology of the large bowel and rectum in relation to modern surgery and treatment. He also gives a detailed account of the use of the sigmoidoscope. Every surgeon

should read what Mummery has written on antiseptic technique and diet in relation to operations on the rectum. It does not necessarily follow that because the rectum and colon are dirty that they are septic. Mummery points out that the rectal mucous membrane as regards the number and quality of its organisms compares most favourably with that of the mouth and that bacteriological examinations show, if a special aseptic technique is used, it is possible to render the parts quite aseptic. We heartily agree with him that it cannot be emphasized too much that many failures in colon and rectal surgery are due to the fact that this fundamental principle has not been grasped.

The author brings a long experience and a critical mind to bear on the subject of chronic constipation and intestinal stasis and there are few who will disagree with him. His opinion and the experiences in his own practice which he gives, should lessen some of the experimental surgery practised on the large bowel. He gives a very insignificant place in treatment to the operation of colectomy or ileo-sigmoidostomy and he sums up this important subject by saying: "There are undoubtedly cases in which the large intestine has so completely lost its normal function as to become a useless sac in which the products of digestion accumulate and decompose with disastrous results to the patient's general economy. In such cases colectomy is the rational treatment and may be expected to give good results; but cases should never reach this stage and in the future, when scientific medical treatment has come into its own, colectomy for stasis will be unnecessary."

In the latter part of the book the author deals fully with malignant disease of the colon and rectum and its operative treatment. The abdomino-perineal recto-sigmoid resection with formation of artificial anus has given the best results in Mummery's practice. He finds that the restitution of continence by bringing the sigmoid down to the sphincter is often possible and successful, but the uncertainty of the circulation makes the operation dangerous.

The book is well illustrated and published. It is Mummery's own work and practice that he gives and apart from its great value it is most entertaining to read, because it is interspersed with anecdotes and interesting experiences in daily work and many practical hints and methods and prescriptions are given for treating the many diseases of the rectum. It will be found useful to every practitioner, but of especial interest to the surgeon.

BACTERIOLOGY FOR NURSES.

THE second edition of Eisenberg's "Principles of Bacteriology" retains its general characteristics as regards the arrangement of subject matter, the additions and alterations being confined to textual details.¹ The book is intended to be a text-book for nurses. The subject matter is well arranged and in each chapter dealing with individual micro-organisms a section has been introduced on mode of infection, disinfection, prophylaxis and immunity. In addition detailed directions of the simpler technical procedures have been gone into with the idea of training nurses as laboratory assistants and technicians during the war. The book is well adapted for its general purpose, but its general excellence is detracted from by a number of inaccuracies which have crept in. Some of them have been subsequently corrected, but to the untrained mind this would only tend to cause confusion. For instance, on page 185 he says: "The antigen used in the Wassermann reaction is a preparation from the *Spirocheta Pallida*"; and again on page 36: "Ptomaines are highly poisonous and responsible for ptomaine poisoning." He apparently still firmly believes that the bacillus discovered by Plotz in 1914 is the cause of typhus fever.

The book is well illustrated mostly by reproductions from well known text-books.

¹"Diseases of the Rectum and Colon and Their Surgical Treatment," by P. Lockhart-Mummery, F.R.C.S. (Eng.), M.A., M.B., B.C. (Cantab); 1923. London: Baillière, Tindall and Cox; Demy 8vo., pp. 882, with five coloured plates and 215 figures in the text. Price: 25s. net.

¹"Principles of Bacteriology," by Arthur A. Eisenberg, A.B., M.D.; Second Edition; 1923. St. Louis: C. V. Mosby Company; Post 8vo., pp. 214, with forty illustrations. Price: \$2.25.

The Medical Journal of Australia

SATURDAY, APRIL 5, 1924.

A Pacific Medical Service.

THE subject of the gradual depopulation of the islands of the Pacific region is not one merely of academic or anthropological interest. It is not a matter which may be called in question. Anthropologists and medical hygienists have stated emphatically that the process is surely and gradually taking place. The facts and figures as recorded in the discussions at the Pan-Pacific Science Congress of August, 1923, speak for themselves. Naval and military strategists and those connected with international diplomacy have associated it with questions which are of vital importance as far as Australia, situated as it is in the Southern Hemisphere, is concerned. Although the subject concerns medical practitioners from the national point of view as it does every other individual resident in the Commonwealth, it is as medical hygienists that they are most interested. They necessarily approach the problem with the object of the prevention and elimination of disease, they strive to ameliorate the lot of the individual and by improving the surroundings in which he is placed, and teaching him a proper appreciation of healthy modes of living to make him a more satisfied and useful member of the community.

At the present time the number of methods of control or lack of control of the public health in the Pacific region is well nigh legion. Great Britain, France, America, Holland and Japan each have extensive possessions in the Pacific and in addition there are the territories whose government is administered by mandate from the League of Nations. Not only is this the case, but the administration at any rate of the British possessions is again operative through several different channels. The Colonial Office of the Government of Great Britain has its own departmental activities. Officers appointed by this body have no recognized association with those controlling neighbouring British

territories and are answerable only to the home authorities. New Zealand and Australia have their own spheres of influence. In regard to the Commonwealth of Australia an interesting condition of affairs exists in New Guinea. That portion of New Guinea known as British New Guinea or Papua is administered by the Minister for Home and Territories and the portion held under mandate from the League of Nations, known as the Territory of New Guinea, is controlled by the Prime Minister's Department. The medical services of these two adjoining areas are quite distinct. It will thus be seen that in some directions in which coordination of effort is possible, much energy is wasted and that in other directions cooperation in the present circumstances is impossible.

The remedy has been suggested. Dr. J. H. L. Cumpston, the Director-General of Health for the Commonwealth, speaking at the Pan-Pacific Science Congress, pointed out that the islands could be divided into five groups. He held that the problem could be adequately handled by the establishment of five properly equipped bases under the control of one coordinating body. Dr. Cumpston's claim that the right body to attack the question is the International Health Board has already been the subject of comment in the pages of this journal. The advantages of such a scheme are many. In the first place much more definite information would probably be forthcoming in regard to the incidence of disease already existent in the different areas. More exact data would be obtained as to the vectors of disease to human beings. Useful as all this would be, the preventive aspect of disease is that which would naturally come into prominence. Of primary importance there is the question of uniformity of quarantine regulations. This was exemplified in the influenza pandemic of 1918. Native races are notoriously susceptible to infections peculiar to and introduced by the white man; once an infection is introduced it is much more lethal than among whites. During the influenza pandemic a rigid quarantine was observed in Australian waters not only for incoming, but also for outgoing vessels. The effect was that no epidemic focus in the islands was traceable to vessels from Australian waters. Outgoing quarantine was not observed in

other countries and the result was disastrous. At the present time as Dr. Armstrong, of Samoa, has pointed out there are no restrictions on inter-island trade in regard to the presence of disease in different ports and there are no means of ascertaining the presence of epidemic disease in a neighbouring island or group of islands. In addition to an effective quarantine service the inauguration of a pacific medical service would lead to some uniformity in methods of control of such diseases as tuberculosis and leprosy. The former is probably the greatest cause of death among native races in contact with white people. Its incidence is in a large measure due to a lack of proper understanding of European dress and methods of living. The latter disease is eradicable and cannot be regarded as other than a blot on the escutcheon of modern civilization. The list of diseases could easily be extended.

It is sincerely to be hoped that the inception by the International Health Board of this important piece of work will not remain merely an idle dream. Its ability to organize such a large scheme has been evidenced in the work it has already undertaken. The direct methods of procedure adopted by its workers have gained the confidence of the authorities in many countries. As a coordinating body it can be trusted by everyone concerned.

Current Comment.

SCLERODERMA.

DR. HOLMES À COURT's report of two cases of scleroderma, published in this issue, is a valuable contribution. He gives a clear and concise picture of the condition as it affected his two patients. The subject is one of great importance from the point of view of differential diagnosis, if from no other standpoint. The serious consequences to an individual of confusing his condition of atrophic scleroderma accompanied by sclerodactylia with leprosy should always be borne in mind. The numerous hypotheses held in regard to the causation of the disease are sufficient indication that its pathogenesis is still undetermined by the scientific investigator.

Dr. Allan W. Rowe and Dr. Francis H. McCrudden have recently reported a case of the atrophic type of generalized scleroderma very similar to that described by Dr. Holmes à Court.¹ In discussing the condition of their patient they make some observations which are of interest, though they do not throw any light on the ultimate cause of the dis-

ease. They discuss the relationship of structure to function in muscles, joints, bones, nervous system and skin as found in various pathological conditions. Healthy nutrition and functioning power of the systems of the body are interdependent. In the first place they point out that the structure and density of bone change with the variations in stress and strain to which it is subjected. Abnormalities of structure and density may result from disease not only of the bone itself, but also from disease of the joints, muscles and nervous system. Secondary bone atrophy occurs in such conditions as hypertrophic and atrophic arthritis and various kinds of myopathies. The atrophy of muscles encased in plaster of Paris for any length of time is well known. Normal activity and work, on the other hand, are the means of maintaining normal structure and density. The nervous mechanism also has a controlling influence and the effects of its failure are seen in such conditions as Charcot joints of *tuberculous* and of syringomyelia and in the osteoporosis of cerebral palsies, polio-myelitis, *tuberculous* and syringomyelia. Changes in the muscular system—wasting and atrophy—occur as a result of bone disease, disease of the nervous system and of the lower motor neurone. Associated with disease of the nervous system are found trophic changes in the skin and nails. These are seen in *tuberculous* and the peripheral and central palsies. Drs. Rowe and McCrudden state that these well known findings are supplemented by the bone, joint and muscle changes secondary to the skin disease in their patient. Although the bone and muscle changes in their patient have appeared prominent enough to lead at times to a diagnosis of atrophic arthritis and *myositis ossificans progressiva*, X-ray examination in the early stages of the skin diseases failed to reveal the presence of changes in the bones or joints. The secondary atrophic changes appeared in the bones and joints as a result of the almost complete immobilization resulting from the extreme stiffening of the skin. There was no evidence of disease of the muscles, the only change was secondary atrophy. Drs. Rowe and McCrudden state that as disease of the joints, bones and muscles can lead to secondary changes in the skin, so scleroderma can lead to secondary changes in the joints, bones and muscles. They claim that the history and the findings in their patient add further weight to the evidence pointing to disuse atrophy as a cause of disease.

In considering the statements of Drs. Rowe and McCrudden it must be remembered that it is easy to regard two associated phenomena as standing in causal relationship to one another. Disuse probably does play a part in the bony atrophy associated with scleroderma, but this is not proved. Much less can it be maintained with justification that the atrophy is wholly due to disuse. The pathogenesis of scleroderma is not by any means determined and it is not beyond the range of possibility that the bony changes may be at any rate partly due to vascular changes which take a share in the production of the lesions in the skin and subcutaneous tissues.

¹ The Boston Medical and Surgical Journal, January 24, 1924.

ACUTE PANCREATITIS.

SIMPLE incision of the pancreas or intra-peritoneal leakage of pancreatic secretion from incision of the pancreatic duct does not cause a reaction to take place. The pancreatic secretion is innocuous unless it is activated. Activation may be brought about by a kinase such as bile, blood, bowel contents or even injury to the tissues. Thus simple ligation of the pancreatic duct does not produce a reaction. If the ligation of the duct, however, is associated with trauma of the pancreas, a pancreatitis will result. The activation consists in the conversion of trypsinogen into trypsin and it is on the activation of trypsin within the gland that the occurrence of acute pancreatitis very largely depends.

With these facts as a basis many efforts have been made to explain the way in which acute pancreatitis is produced. Deaver was amongst those who expressed the belief that acute pancreatitis was a direct extension from infection in the gall bladder. He pointed out that the lymphatics from the gall bladder run directly to the head of the pancreas and that the earliest involvement is always in the upper portion of the head of the gland. Archibald explained the condition as being due to damage caused by bile. He produced pancreatitis in an animal by stimulation of the muscle in the sphincter of Oddi by means of hydrochloric acid on the duodenal mucosa. He thought that bacterial invasion was purely secondary. Others again have held that the real cause of the condition was reflux of duodenal contents. This was for long merely an hypothesis, but it has been shown experimentally that pancreatitis can be produced by obstruction of the bowel with the sphincter intact.

In the course of an exceedingly interesting paper on acute pancreatitis Mr. H. J. Waring and Mr. H. E. Griffiths have discussed the causation of the condition.¹ They express the belief that all cases of acute pancreatitis are due to infection. The infecting organism is nearly always the *Bacillus coli communis*, but occasionally streptococci may be found. Other observers have found a variety of organisms associated with acute pancreatitis. These include the pneumo-bacillus isolated by Marwedel and *Proteus vulgaris*, *Bacillus pyocyaneus* and *Bacillus lactis aerogenes*. It is not unusual to find the material removed at operation to be sterile. Mr. Waring and Mr. Griffiths state that this is probably because the activated pancreatic ferments have killed off the bacteria. There are several routes by which infection may reach the pancreas and they regard it as likely that more than one of them may be used in different cases. There is little doubt that the primary source of infection is generally the gall bladder or the duodenum and infection in the main is spread from these organs to the pancreas by the lymph vessels or by the pancreatic or common bile duct. They point out that in two-thirds of the cases the common bile duct is embedded in the substance of the head of the pancreas and that the

effluent lymph vessels of the gall bladder accompany it. The lymph vessels are in this situation brought into intimate relationship with those of the head of the pancreas; in fact in many instances free communication exists between the two sets of vessels. They point out that on this account infection from the gall bladder may readily cause a pancreatic lymphangitis and act as the starting point of acute pancreatitis. At the same time Mr. Waring and Mr. Griffiths recognize that the occurrence of retrograde infection along with the pancreatic ducts has been definitely proved. In one of the cases reported by them three gall stones were shown to be impacted in the ampulla of Vater and the main pancreatic ducts and the glandular tissue of the organ were deeply stained by bile. On microscopical examination of a section of the organ in this instance it was found that even the minute ducts and acini contained bile pigment. In only one instance, however, of the fifteen which form the groundwork of their paper, was definite evidence found of obstruction in the ampulla of Vater or of regurgitation of bile; jaundice was present in seven instances. They regard it as possible that a spasm of the sphincter of Oddi may cause a transient regurgitation of infection bile, but not in sufficient quantity to stain the body of the pancreas. They can find no case to prove that infection spreads directly from the duodenum along the pancreatic ducts. They only go so far as to state that their work tends to show that the duodenal contents are sterile or nearly so and that micro-organisms do not exist in the duodenum in sufficient numbers to make invasion of the pancreas either likely or formidable. They point out that the view of causation of acute pancreatitis by regurgitation of bile owing to spasm of the sphincter does not explain the fact that the destruction of the pancreas is often patchy. They regard it as more probable that the activating agent in the majority of instances is blood. In the early stages of an acute inflammation of the pancreas congestion occurs and small hæmorrhages are produced. Although the majority of these occur in the interstitial tissue, some will occur in the alveoli and will cause activation of the pancreatic juice. Local auto-digestion then begins, small blood vessels are opened and more blood is provided for the activation of trypsinogen. In this way a vicious circle is formed and large areas of tissue are destroyed.

Mr. Waring and Mr. Griffiths make an interesting observation in regard to fat necrosis. On account of its distribution fat necrosis was held to be due to the local action of escaped pancreatic juice. This view is still widely held. They point out that fat necrosis has on more than one occasion been found in the pericardial fat and the extra-pleural fat, places which cannot possibly have been exposed to the direct action of the fluid. They regard it as possible that the occurrence of fat necrosis may be attributed to ferment liberated by the diseased pancreas and circulating in the blood. They have not, however, as would be expected if this were so, found fat necrosis outside the abdomen and thorax.

¹ The British Journal of Surgery, January, 1924.

Abstracts from Current Medical Literature.

DERMATOLOGY.

Pruritus.

FRED WISE (*New York Medical Journal and Medical Record*, December, 1923) makes further observations on neuro-dermatitis of Brocq or *lichen circumscriptus* of Vidal. Numerical data pertaining to the occurrence of diseases classed as eczema in the dermatological clinics present wide variation and discrepancies. Amongst those giving rise to confusion the commonest are the industrial dermatoses, *dermatitis venenata*, *dermatitis artefacta*, the dermatophytoses, pompholyx and dysidrosis and the circumscribed and diffuse forms of pruritus with lichenification or neuro-dermatitis of Brocq. There are two main types of pruritus with lichenification, primary and secondary. The primary type commences on apparently healthy skin and at the outset there is no visible lesion in the integument. Gradually the tissues change as a result of the scratching. They first lose their normal colour and assume a slightly dusky or pinkish tint. The skin is seen to present a fine granular or mottled appearance. The lesions later on become more pronounced. They become dusky red in colour and manifest the roughened and furrowed surface pathognomonic of the condition. The secondary pruritus with lichenification is practically the same except that instead of the patch being preceded by pruritus affecting an apparently normal skin, the lichenification is superimposed upon an already diseased skin. This is itchy and is continually scratched by the patient. Histologically according to Alexander there are three prominent points in which eczema and pruritus with lichenification differ from one another. In neuro-dermatitis despite the high grade of oedema in the cutis and the epithelium the stage of vesicle formation is absent, whereas in eczema it constitutes the most prominent feature. Neuro-dermatitis in its papular stage is characterized by a distinct displacement of the pigment of the basal layer associated with a certain hyperpigmentation of the epithelium in the less affected surrounding areas. In neuro-dermatitis there is an invasion of the epithelium by wandering leucocytes emanating from the papillary and subpapillary infiltration so that the epithelium is studded with wandering cells. This is sometimes so pronounced as to cause a breaking up of the interpapillary prolongations of the cutis.

Lupus Erythematosus.

J. H. M. MACLEOD (*Archives of Dermatology and Syphilology*, January, 1924) publishes observations based on a study of two hundred cases of *lupus erythematosus*. He mentions certain

predisposing causes such as climate, season, light, the direct rays of the sun having an unfavourable influence as a rule, circulatory disturbances and histological considerations. He considers the actual causes under the headings of three main theories—the local theory, the tuberculous theory and the toxic or septic theory. With regard to the local theory he is unable to recall any instance in which a local injury or external irritant, except perhaps the sun's rays, has been the initial cause. With the tuberculous theory he also disagrees except in so far that the latter may act as a predisposing factor by weakening the tissues or depressing the peripheral circulation and he is of the opinion that the association of a certain number of instances with tuberculosis has been due to an error of diagnosis from mistaking that peculiar superficial symmetrical type of true *tuberculosis cutis* described by Lelior as *lupus erythematosoides* for *lupus erythematosus*. Although these two conditions resemble one another very closely on superficial examination, histologically they are totally different. With regard to the toxic or septic theory, for some time the prevalent opinion amongst British dermatologists has been that *lupus erythematosus* is not a local dermatitis resulting from some cutaneous irritant nor is it due to reaction of the skin to the presence of some micro-organism *in situ* like *lupus vulgaris*. In other words it is not a pathological entity due to some specific cause, but rather a cutaneous symptom of a peculiar type which may be called forth by a variety of causes toxic or septic in character. Just as acute examples of the condition may be regarded as being due to a general toxæmia or septicæmia, so the chronic forms may in some instances be due to a focal sepsis, that is protein poisoning from bacteria from a crypt or from the intestinal tract, a possibility which has been recently advocated.

X-Rays and Dermatology.

HOWARD FOX (*Archives of Dermatology and Syphilology*, January, 1924) discusses the use of X-rays in the treatment of skin diseases. After a brief survey of the methods used in measuring doses he comes to the conclusion that the indirect method is preferable and simpler, is more accentuated and eliminates the personal equation. In his opinion X-rays are the best local remedy for the routine treatment of *acne vulgaris*, eczema, seborrhœic dermatitis and *lichen planus*. Treatment with X-rays is the most suitable method for use in ringworm of the scalp, sycosis and folliculitis. Many other skin diseases are mentioned, such as hyperidrosis, pruritus *et cetera* in which the results have been excellent.

Erythema Nodosum.

W. RIDGELEY STONE (*New York Medical Journal and Medical Record*, December, 1923) calls attention to the association of *erythema nodosum* with

streptococcal infection of the fauces. *Erythema nodosum* has long been recognized as a complication or sequela of rheumatic fever and the establishment of bacterial origin of rheumatism seems to presuppose that all forms of *erythema nodosum* are due to some bacterial cause.

Hypertrichosis.

LAWRENCE K. MCCAFFERTY (*New York Medical Journal and Medical Record*, December, 1923) goes into the question of hypertrichosis and its treatment. He divides hypertrichosis into two main divisions, congenital and acquired. The congenital variety may be partial or universal. Partial forms are represented by the hairy mole and the universal type, though rare, does not exist and is due to a persistence of the lanugo hairs. The acquired type is of more interest to the dermatologist and usually occurs in women between the ages of eighteen and thirty years. In women past the climacteric only a few scattered hairs or an occasional tuft are seen. The evidence in regard to the ætiology of acquired hypertrichosis points to a disturbance in the endocrine system. Falta declared that a pathological process beginning in one gland would to a greater or less extent cause disease in all the others. The internal secretion of one gland reaching the others through the circulation either increases or inhibits their functional activity. Draper reports instances in which a striking picture of virility with secondary sex characteristics was associated with tumours of the adrenal cortices. Other observers state that hypertrichosis is the result of functional organic derangement of the ovaries.

Vitiligo.

SAMUEL AYRES (*Archives of Dermatology and Syphilology*, October, 1923) reports an instance of vitiligo and *alopecia areata* associated with severe hyperthyroidism. The author states that the endocrine origin of certain cases of vitiligo and *alopecia areata* is becoming recognized by most authorities.

Chalasoderma.

PARKES WEBER (*The Urologic and Cutaneous Review*, July, 1923) states that three main types of chalasoderma are described. In one type, that of true elastic skin, there is an excess of elasticity with imperfect attachment of the skin by the subcutaneous fibrous trabeculae to the deeper structures. In another type there seems to be a deficiency in true cutaneous elasticity with a hyperplasia of the white connective tissue elements. Between these two there is an intermediate type in which the skin is abnormally movable. The condition is frequently associated with multiple small subcutaneous fibromata or calcareous nodules and also a certain amount of physical and mental defectiveness.

RADIOLOGY.

Radiation in Malignancy.

R. HUGHES PARRY writes on the experimental pathology for radium therapy in malignant disease (*British Journal of Radiology*, January, 1924). The author points out that during the past twenty-five years all experimental work has proved that radiation therapy is built upon a firm basis. The paper is divided into two parts. The first is devoted to the consideration of some of the main general and local effects of radiation of malignant tumours and the second part to the application of this knowledge in treatment. In concluding the author considers that both X-rays and radium have their advantages and disadvantages. X-ray tubes supply a far larger dose of radiation than is possible with limited supplies of radium, but X-rays lack the penetrating properties of radium rays. Radium application implies a concentration of the radiations locally and a focus of irradiation of small bulk. This is useful in small growths, but not in large ones. Up to the present radiation has been confined to inoperable conditions, but even so the diminution of the tumour is remarkable and pain is relieved and often growths become operable after irradiation. Bad results are due to inefficient technique and to failures in recognizing contra-indications. There is an optimum dosage to be given so that growth of the neoplastic cells, but not their power for inducing active immunity, is destroyed whilst the damage to the healthy structures is reduced to a minimum.

Fœtal Radiography.

T. I. CANN contributes an article on radiography of the *fœtus in utero* (*Archives of Radiology and Electrotherapy*, October, 1923). He refers to the great technical difficulties and for this reason most of the published skiagrams have been indistinct and of little value to the obstetrician. The writer considers it possible to show the fœtus after the sixth month. The earliest demonstration that he has made of the fœtus, was at four and a half months. Potter-Bucky diaphragm is used and a wide compression binder. The patient lies face downward and the chest is raised on pillows. The tube is centred over the third lumbar vertebra posteriorly and large duplitzed films and double intensifying screens are used. An exposure of five seconds and a spark gap of 13.75 centimetres (five and a half inches) is used. No danger can result to the fœtus or to the mother from this procedure.

IRVING F. STEIN AND ROBERT A. ARENS have made a series of observations on radiograms of the fœtal skeleton as a sign of pregnancy (*The Journal of the American Medical Association*, July 7, 1923). The signs of pregnancy are noted by the physician after quickening, namely fœtal heart sounds and movements and the

palpable fœtal parts. The authors claim that they can demonstrate the pelvis *in utero* and in some cases can even demonstrate the hands and feet at six months, while in the last three months convincing radiographic signs may always be demonstrated. This method is most useful in checking up deflection altitudes and suspected transverse, breech and oblique presentations, while stereo-radiograms at term reveal the relation between the fœtal head and the bony inlet and also bony abnormalities of the pelvis. The authors find a reducing biconcave lens of use in studying this type of picture and it gives a pseudo-stereoscopic appearance to the negatives. It is not possible to estimate the age of the fœtus by radiographic study. All patients are examined in the recumbent, prone, right lateral and left lateral position. A current of twenty milliamperes at from 80,000 to 90,000 volts is used and exposures vary from ten to twelve seconds. A Potter Bucky diaphragm is used with varying distances of 62.5 to 70 centimetres (twenty-five and twenty-eight inches) according to the size of the patient. The exposures are made with double screens and duplitzed films.

Metatarso-Phalangeal Arthritis.

ALBAN KOHLER (*American Journal of Roentgenology*, September, 1923) in 1920 reports cases of a rare pathological condition affecting the metatarso-phalangeal joint of the second toe. The condition involves the articular surface of the base of the proximal phalanx of the second toe and the head and distal part of the shaft of the second metatarsal. The articular surface of the phalanx loses its usual form and becomes irregular in outline. The joint space becomes broader than normal and this is irregular in character with loss of the usual roundness of the head of the second metatarsal and apparent shortening of the shaft. The joint and metatarsal has the appearance of being "knocked up." The distal part of the shaft broadens. The disease occurs during the growing age (ten to eighteen years) and is commoner in females in the proportion of four to one. The patient complains of localized pain especially when bearing weight and is liable to limp and rest the foot. The soft parts may be the site of some swelling. Very little is known of the etiology, but trauma has some part in its production. Conservative treatment is recommended and no operation should be undertaken until after the growth period.

Sella Turcica.

ROBERT KNOX (*Archives of Radiology and Electrotherapy*, December, 1923) describes the symptoms of disease of the *sella turcica*. A certain latitude must be allowed in measurement of the sella as in big heads the sella is larger than in small ones. Two chief conditions show enlargement of the sella as a constant feature, namely acromegaly and tumour of the pitu-

itary fossa. In acromegaly the increase is regular and the sella is equally distorted and its outline may remain unaltered. In later stages the sphenoidal cells are encroached upon and may be obliterated. Acromegaly is common in females and usually begins about the twenty-fifth year. The hands and feet enlarge and the head increases in volume and the face enlarges and elongates. Ocular symptoms are common. Disease of the pituitary gland is now regarded as the most probable cause of acromegaly. The gland may be the seat of simple hyperplasia or of carcinoma or sarcoma. The presence of new growth leads to increase in distance between the clinoid processes, unequal enlargement of the sella and later destruction of the walls of the sella.

Gall Bladder Pathology.

RALPH D. LEONARD contributes an article on secondary signs in gall bladder pathology (*American Journal of Roentgenology*, July, 1923). He divides evidence of gall bladder pathology into two groups, direct and indirect. In the former class are demonstrable stones and visible gall bladders while in the latter are put the demonstrable changes produced in other organs by gall bladder disease. The author considers the indirect evidence of the greatest importance. Pressure deformities are produced by the enlarged and thickened gall bladder and the duodenum is most frequently affected by pressure, giving a typical flattening of the cap. Pressure is also frequently present on the pyloric antrum. Fixation of the stomach and duodenum is frequently noted and here fluoroscopic examination is of the greatest help. The hepatic flexure is also frequently fixed by adhesions. Spasm of the pyloric antrum is frequently seen in gall bladder disease. If the ampulla of Vater is demonstrated, it generally points to gall bladder lesions. Care must be taken not to interpret the shadow of the right kidney as a gall bladder shadow. In conclusion the author insists upon the combination of direct radiography with opaque meal examination.

The Lumbar Transverse Processes.

MORRIS I. BRENNAN (*American Journal of Roentgenology*, June, 1923) discusses anomalies of the transverse processes of the lumbar vertebrae. In the fifteen millimetre embryo, chondrification of the vertebrae is taking place and each vertebra is provided with rib processes which in the cervical, lumbar and sacral regions become part of the vertebrae. In the lumbar region, union of the various main centres occurs about the sixth year, while the secondary centres unite with the vertebrae at any time between the sixteenth and twenty-fifth year. In some cases the lumbar transverse process develops as a lumbar rib and is frequently mistaken for a fracture. Lumbar ribs and jointed transverse processes occur in from 5% to 10% of patients examined.

British Medical Association News.

ANNUAL MEETING.

NEW SOUTH WALES BRANCH.

THE ANNUAL MEETING OF THE NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held at the B.M.A. Building, 30-34, Elizabeth Street, Sydney, on March 27, 1924, Dr. C. H. E. LAWES, the PRESIDENT, in the chair.

Death of Sir William Macewen.

THE PRESIDENT made reference to the death of Sir William Macewen. He had been among them so recently that his death was a personal loss as well as a loss to medical science. The Council has written a letter of condolence to his relatives.

Annual Report of Council.

THE HONORARY SECRETARY presented the Annual Report of the Council and moved that it be taken as read and received. The motion was seconded by Dr. A. P. WALL and carried.

ANNUAL REPORT OF THE COUNCIL, MARCH 27, 1924.

THE COUNCIL presents the following report on the work of the Branch for the year ended March 27, 1924.

Membership.

The membership of the Branch is now 1,323 as compared with 1,240 at the date of the last Annual Report, showing a net increase of 83.

The additions have included figures as follows: Elections and resumptions of membership, 137; removals into area of Branch, 33.

The losses have included: Resignations, 10; removals out of the area of the Branch, 37; default in payment of subscription, 24; deaths, 16.

The losses by death have been: SIR H. L. MAITLAND, DR. L. R. COOK, DR. W. RAE YOUNG, DR. JOHN HARRIS, DR. P. KENNEDY, DR. G. E. RENNIE, DR. W. R. OLVER, DR. W. W. LEAHY, DR. C. C. HUMPHRIES, DR. H. L. CUMMINGS, DR. P. W. R. BOELKE, DR. R. D. MCMASTER, DR. W. T. CHENHALL, DR. W. RITCHIE, DR. W. S. HOLMES, DR. W. E. HARRIS.

Meetings.

Ten ordinary meetings of the Branch, including the Annual Meeting, four extraordinary meetings and seven clinical meetings were held. The average attendance was 69.22. Clinical meetings were held at the Royal Alexandra Hospital for Children, Royal Prince Alfred Hospital, Sydney Hospital, Royal North Shore Hospital, Coast Hospital and Broughton Hall Psychiatric Clinic. The business included twenty-seven papers and addresses and numerous reports of cases and exhibits, as well as lantern demonstrations.

Representation.

The Branch was represented as follows:

- (a) *Council of the British Medical Association*: SIR T. JENNER VERRALL, LL.D., Vice-President of the British Medical Association.
- (b) *Representative Body (1923-24)*: Representative, DR. SINCLAIR GILLIES.
- (c) *Federal Committee of the British Medical Association in Australia (1923)*: DR. J. A. DICK, C.M.G., DR. R. H. TODD; (1924), DR. J. A. DICK, C.M.G., DR. R. H. TODD.
- (d) *Australasian Medical Publishing Company, Limited*: DR. W. H. CRAGO, PROFESSOR F. P. SANDES, DR. R. H. TODD.
- (e) *Council of the Bush Nursing Association (1923-24)*: DR. C. H. E. LAWES.
- (f) *Council of the Royal Society for the Welfare of Mothers and Babies*: DR. R. B. WADE, DR. J. C. WINDEYER.

Council.

(a) The attendance of Members of the Council and of the Standing Committees was as set out in the table on the next page,

(b) The Representatives of the Local Associations of Members appointed on the invitation of the Council to attend the regular quarterly meetings of the Council were as follows: DR. K. S. MACARTHUR BROWN (Central Western), DR. A. M. GLEDDEN (City), DR. J. C. LAMROCK (Eastern Suburbs), DR. W. F. SIMMONS (Illawarra Suburbs), DR. W. B. DIGHT (Northern District), DR. G. M. BARRON (Northern Suburbs), DR. A. I. BLUE (South Sydney), DR. J. MORTON (Western Suburbs), DR. J. BROOK MOORE (Western).

(c) DR. W. H. CRAGO, the Honorary Treasurer, left on a visit to Europe on September 12, 1923, and is expected to return on May 7, 1924. During his absence DR. GEORGE ARMSTRONG kindly undertook the duties of Honorary Treasurer.

Library.

DR. J. A. DICK, C.M.G., was re-appointed Honorary Librarian. Donations of books and periodicals were received from the AUSTRALASIAN MEDICAL PUBLISHING COMPANY, LIMITED, the UNIVERSITY OF MELBOURNE, the GENERAL SECRETARY, BRITISH MEDICAL ASSOCIATION ANNUAL (1922) MEETING (Glasgow), DR. J. MACDONALD GILL, LADY MAITLAND, the QUEENSLAND BRANCH, DR. A. M. DAVIDSON, and others.

Affiliated Local Associations of Members.

The following is a list of the Local Associations of Members, with the names of their Honorary Secretaries:

Balmain District: DR. C. H. WESLEY.

Border: DR. R. AFLECK ROBERTSON.

City: DR. H. A. RIDLER.

Central Northern: DR. I. MORGAN.

Central Southern: DR. R. G. WOODS.

Central Western: DR. K. S. MACARTHUR BROWN.

Eastern District: DR. H. T. MARSH.

Eastern Suburbs: DR. J. C. LAMROCK.

Illawarra Suburbs: DR. W. F. SIMMONS.

Northern District: DR. E. B. FITZPATRICK.

North Eastern: DR. A. M. ASPINALL.

Northern Suburbs: DR. E. M. HUMPHERY.

Southern District: DR. S. H. WEEDON.

South Eastern: DR. H. H. LEE.

South Sydney: DR. R. A. R. GREEN.

Western Suburbs: DR. J. F. WALTON (Assistant Honorary Secretary: DR. W. M. A. FLETCHER).

Western: DR. W. K. DALE.

Annual Meeting of Delegates.

The Twelfth Annual Meeting of the Delegates of the Affiliated Local Associations with the Council was held on October 5, 1923, at the B.M.A. Library, Sydney. An account of the meeting appeared in THE MEDICAL JOURNAL OF AUSTRALIA, 1923, Volume II., page 475, and reports of the proceedings were sent to the Local Associations. A smoke concert was held in the evening at which the Members were invited to meet the Delegates. The Delegates were as follows: DR. W. B. GRANT (Balmain District), DR. C. A. F. CLARK (Central Northern), DR. G. A. BUCHANAN (Central Southern), DR. K. S. MACARTHUR BROWN (Central Western), DR. A. M. GLEDDEN (City), DR. J. B. McELHON (Eastern District), DR. F. G. N. STEPHENS (Eastern Suburbs), DR. W. F. SIMMONS (Illawarra Suburbs), DR. R. M. KINROSS (Northern District), DR. G. M. BARRON (Northern Suburbs), DR. L. FETHERSTON (South Eastern), DR. R. B. TRINDALL (South Sydney), DR. F. W. KANE (Western Suburbs), DR. J. H. WILSON (Western).

Sections for Special Branches of Medical Knowledge.

(a) *Section of Paediatrics (inaugurated October 4, 1921).*

The officers were: *Chairman*, DR. J. MACDONALD GILL; *Vice-Chairmen*, DR. R. B. WADE, PROFESSOR A. E. MILLS; *Committee*, DR. C. P. B. CLUBBE, DR. E. S. LITTLEJOHN, DR. HARVEY SUTTON, DR. M. J. PLOMLEY, DR. MARGARET HARPER, DR. H. G. HUMPHRIES; *Honorary Secretaries*, DR. E. S. HARRISON (resigned), DR. WILFRED VICKERS, DR. H. G. HUMPHRIES; *Honorary Treasurer*, DR. E. H. M. STEPHEN. Meetings were held on April 18 (Annual), May 16 (in conjunction with the Section of Hygiene and Preventive Medicine); September 6 (in conjunction with the Section of Orthopaedics at the Royal Alexandra Hospital for

Children); September 20 (at Blackfriars Practice School); December 7 (at Royal Alexandra Hospital for Children); February 15; March 14 (Annual).

(b) *Section of Orthopaedics (inaugurated May 7, 1923).*

The officers were: *Chairman*, Dr. R. B. WADE; *Vice-Chairman*, Dr. N. D. ROYLE; *Secretary*, Dr. D. J. GLISSAN; *Treasurer*, Dr. L. G. TEECE; *Committee*, Dr. A. J. ASPINALL, Dr. S. H. SCUGALL. Meetings were held on May 17, June 21, July 12, August 2, September 6, October 4, November 1, December 6, 1923, and March 6, 1924.

(c) *Section of Hygiene and Preventive Medicine (inaugurated January 3, 1922).*

The officers were: *Chairman*, Dr. W. G. ARMSTRONG; *Vice-Chairman*, Dr. C. E. CORLETTE and Dr. C. W. REID; *Honorary Secretary*, Dr. ROBERT DICK. A meeting was held May 16 (in conjunction with the Section of Pædiatrics).

Public Hospitals Act Amendment.

At the invitation of the Chief Secretary and Minister for Public Health, the HONOURABLE C. W. OAKES, M.L.C., Dr. C. H. E. LAWES, Dr. GEORGE ARMSTRONG and Dr. T. W. LIPSCOMB, as representatives of the Council, attended a Conference on May 29 and 30, 1923, of those experienced in hospital management, to discuss a Bill to be submitted to Parliament for the purpose of modernizing the hospital legislation of the State. A further Conference was held on December 3, 1923, which was attended by Dr. T. W. LIPSCOMB and Dr. R. H. TODD, on behalf of the Council, when the principal provisions of the rough draft of the proposed Bill were discussed.

Baby Clinics.

Replies were received from the Under Secretary, Chief Secretary's Department, to a series of questions in refer-

ence to the relations of the Baby Clinics to medical practitioners which were submitted to him at the instance of the Illawarra Suburbs Medical Association. The replies were communicated to the Local Associations of Members in the Metropolis and Newcastle and have helped to define the position of the Baby Clinics medical officers. It is felt that the work of the Baby Clinics would be more satisfactorily performed if they were under immediate medical control and there appears to be need for regulations to be made for the guidance of the medical officers and the nurses. The views of the Council in these respects have been brought to the notice of the Under Secretary.

Post-Graduate Courses in Medicine.

The first and second Post-Graduate Medical Courses at the Sydney University, organized by the Council and conducted by the University Extension Board, were held in January, 1922 and 1923, respectively. A proposal for a 1924 Course, to be held in September, as likely to be a more suitable time of the year for the purpose than January, has been forwarded to the Faculty of Medicine and is to be considered at an early date.

Regulations—Advertisement.

The attention of members was drawn to the Warning Notice of the General Medical Council of the United Kingdom on the subject of "Advertising and Canvassing," as amended by the General Medical Council, June 1, 1923, and published in *The British Medical Journal Supplement* on June 9, 1923, as follows:

"The practices, by a registered medical practitioner—

- (a) Of advertising, whether directly or indirectly, for the purpose of obtaining patients or promoting his own professional advantage; or, for any such purpose, of procuring or sanctioning or acquiescing

ATTENDANCE OF MEMBERS OF THE COUNCIL AND OF THE STANDING COMMITTEES OF THE COUNCIL.

Office-Bearers.	Council.	Executive and Finance Committee.	Ethics Committee.	Organization and Science Committee.	Medical Politics Committee.	Medical Journal Sub-Committee (Executive and Finance Committee).
DR. GEORGE ARMSTRONG (Acting Honorary Treasurer, September, 1923, to May, 1924)	12	10	—	—	—	7
DR. J. E. V. BARLING	6	—	2	—	—	—
DR. F. BARRINGTON	11	9	—	—	—	6
DR. C. B. BLACKBURN, O.B.E.	7	—	4	—	—	—
DR. W. H. CRAIG (Honorary Treasurer; Premises Attorney)	7	6	4	2	8	3
DR. F. BROWN CRAIG (Honorary Medical Secretary)	12	—	—	11	—	—
DR. A. DAVIDSON (Vice-President)	10	7	7	3	13	—
DR. J. A. DICK, C.M.G. (Honorary Librarian)	12	10	—	—	16	—
DR. J. G. W. HILL	10	—	—	—	14	—
DR. E. M. HUMPHREY	12	—	6	—	—	—
DR. SYDNEY JAMIESON	10	9	—	—	—	—
DR. C. H. E. LAWES (President)	12	12	1	3	11	8
DR. T. W. LIPSCOMB (Ex-President)	12	11	—	—	16	6
DR. R. J. MILLARD, C.M.G.	8	—	—	—	8	—
PROFESSOR A. E. MILLS	11	—	—	10	—	—
DR. W. C. MCCLELLAND	9	—	—	—	8	—
DR. A. A. PALMER	11	—	8	—	—	—
DR. S. A. SMITH	9	—	—	9	—	—
DR. R. H. TODD (Honorary Secretary)	11	13	9	11	10	8
DR. R. B. WADE	11	—	9	9	—	—
Number of Meetings Held	12	13	9	11	16	8

in the publication of notices commending or directing attention to the practitioner's professional skill, knowledge, services, or qualifications, or depreciating those of others; or of being associated with or employed by those who procure or sanction such advertising or publication; and

- (b) Of canvassing or employing any agent or canvasser for the purpose of obtaining patients; or of sanctioning, or of being associated with or employed by those who sanction such employment;

are in the opinion of the Council contrary to the public interest and discreditable to the profession of medicine, and any registered practitioner who resorts to any such practice renders himself liable on proof of the facts to have his name erased from the Medical Register."

Contract Practice—Friendly Society Lodges.

The approved Common Form of Agreement for use between Medical Officer and Friendly Society Lodge has continued to work smoothly and with satisfaction both to the Lodge members and to the Medical Officers. The number of members who undertake Friendly Society Lodge practice is 570.

Proposals have been made to the Friendly Societies' Association: (i.) That, in the case of transferred members added to the medical officer's list, the name of the lodge from which such members are transferred may be given; (ii.) that, in regard to the medical officer's certificate of sickness, progressive certificate and certificate of member's ability to resume employment, uniform forms of certificate may be adopted for use by all orders and all lodges; also that uniformity in the Medical Certificate of Health and Form of Proposal for Membership be adopted.

It is understood that, in respect of widows and orphans of deceased soldiers whose death is due to war service and to the widowed mothers of such deceased unmarried soldiers, arrangements are in progress by the Repatriation Commission for medical benefit to be supplied to them through the friendly society lodges in the several States.

Australian Natives' Association, Limited, and Phoenix Mutual Provident Society, Limited.

At the request of the Australian Natives' Association, the question was re-opened of extending recognition to it in connexion with contract medical benefit attendance on its members, although it is no longer a friendly society, but a limited liability company. The matter was discussed by the several Local Associations of Members and was considered at the Annual (1923) Meeting of Delegates of the Local Associations with the Council, when a resolution was passed recommending that no alteration of the existing rule should be made. The rule (Regulations—Contract Attendance, Friendly Society Lodges, Regulation 5) reads as follows:

No member shall accept on his list for medical benefit members of the Australian Natives' Association, the People's Prudential Benefit Society or the Phoenix Mutual Provident Society, Limited.

Visitors.

DR. W. WATKINS-PITCHFORD, Director of the South African Institute for Medical Research, Chairman of the South African Miners' Phthisis Bureau at Johannesburg, and a Vice-President of the British Medical Association, visited Australia in connexion with the Pan-Pacific Science Congress. He was pleased to have the opportunity of meeting the members of the Branch and gave an address at the Branch Meeting of August 29, choosing as his subject, "The Causation and Nature of Miners' Phthisis."

SIR WILLIAM MACEWEN, C.B., F.R.S., LL.D., M.D., F.R.C.S., D.Sc., D.C.L., Professor of Surgery in the University of Glasgow, one of the Surgeons to the King in Scotland, Honorary Admiral of the British Navy, President (1923) of the British Medical Association, visited Australia as Representative of the British Medical Association at the Australasian Medical Congress (British Medical Association), First Session, 1923, Melbourne. He arrived in Sydney, accompanied by his son, DR. WILLIAM MACEWEN, on October 15 and proceeded to Melbourne on October 31.

During part of his visit he was the guest of Sir Alexander MacCormick. He was the guest of the members of the Branch at a dinner at the Australia Hotel on October 25 and attended a meeting of the Branch at the Anatomy School at the University on October 26.

Arrangements are in progress for the recognition and entertainment of Dr. W. J. MAYO, of the Rochester Institute, U.S.A., who is paying a short visit to Australia between March 25 and April 10, also of the Officers of the Royal Naval Medical Service in the ships of the Royal Naval Squadron due to arrive at Sydney on April 9.

Cooperation of the Medical Profession in the Public Health Administration.

The attention of members is drawn to a report of a Sub-Committee of the Federal Committee of the British Medical Association in Australia on the subject of "Cooperation of the Medical Profession with the Commonwealth Department of Health," printed in THE MEDICAL JOURNAL OF AUSTRALIA of March 22, 1924, in which a scheme is outlined for the association of the members of the profession engaged in private practice with the public health administration of the States and the Commonwealth in regard to measures of preventive medicine. Although the difficulties in the way of introducing such a scheme are obvious, the Council is of opinion that members should give very careful consideration to it as indicating lines along which the services of medical practitioners can be utilized for public health purposes with advantage to the administration and without sacrificing the interests of the profession or the relations of its members as private practitioners with their patients.

The Thompson Case.

The Full Court Judgement in the Appeal of the Association against the verdict of the jury, in the action brought against the Branch by Dr. G. S. Thompson, was delivered on May 7, 1923. The verdict of the jury was set aside and a verdict was entered for the defendant Association. The plaintiff appealed to the Privy Council against the judgement of the Full Court. The Appeal was heard February 8 to 11, 1924, and judgement was reserved.

Relationship Between the Parent Association and Overseas Branches.

A further step has been taken in providing for Branches in Australia which wish to do so, to become corporate bodies, in accordance with the Articles and By-laws (Article 12 and By-laws 16 and 17) of the British Medical Association by the drafting of Model Memorandum and Articles of Association for their use. The Model was approved by the Council of the British Medical Association at its meeting held on February 13, 1924. It will now be a comparatively simple matter for a Branch to become a company with limited liability not for profit. So far as the New South Wales Branch is concerned, it will be necessary to adopt new articles of association and to make by-laws under them embodying the existing Regulations as may be appropriate.

Federal Committee.

The Federal Committee of the British Medical Association in Australia met in Sydney, July 18 and 19, 1923; in Melbourne, November 13, 1923, and February 26 and 27, 1924. Reports of the proceedings appeared in THE MEDICAL JOURNAL OF AUSTRALIA, 1923, Volume II., at page 128 and page 662; and 1924, Volume I., at page 270.

Australasian Medical Congress (British Medical Association).

That the First Session of the Congress, held in Melbourne, November 12 to 17, 1923, was a triumph of organization and management is a matter for hearty congratulation to the members of the Victorian Branch, to whom its conduct was entrusted. The material presented to the sectional meetings was of high scientific value and the entertainment of visiting members was both generous and gracious. One hundred and sixty-four members of the New South Wales Branch were members of Congress.

The Federal Committee has determined that the Second Session shall be held in 1926 and has been invited by the New South Wales Branch to arrange for it to be at Sydney.

Royal Commission on National Insurance.

In September, 1923, a Federal Royal Commission was appointed to inquire into and report upon: (a) National insurance as a means of making provision for casual sickness, permanent invalidity, old age and unemployment and (b) the operation of the maternity allowance system with a view to the incorporation with national insurance of a scheme for securing effective pre-natal and other assistance to mothers.

It is expected that the Commission will report in favour of some scheme of national (health) insurance, the main feature of which will be a system of compulsory medical and sickness benefit for wage earners and others with incomes not exceeding £300 or perhaps more than £300. Each of the Branches of the Association was invited by the Commission to nominate representatives to give evidence before the Commission with respect to the present arrangements relating to medical attendance on members of friendly societies and other similar organizations together with the question of their incorporation in a scheme of national insurance. The representatives of the New South Wales Branch, DR. C. H. E. LAWES, DR. T. W. LIPSCOMB and DR. R. H. TODD, gave evidence before the Commission on December 11 and 12, 1923. At the request of the Federal Committee the members of the Branch have been asked to indicate their views in regard to the adoption of a scheme for national insurance with medical benefits in Australia by returning answers to certain questions submitted to them with a view to evidence being given by a representative of the Federal Committee on behalf of the Association in Australia as a whole.

The Medical Journal of Australia.

The proposal of the Directors of the Australasian Medical Publishing Company, Limited, to erect or purchase suitable premises and to instal the necessary linotypes, printing presses and the accessories of a complete printing establishment, which was approved by the Branch in

January, 1923, in common with the Branches in the other States, has been further developed and the amount, £15,000, required for the purpose, has been subscribed by the members of the Association in the several States. Members of the New South Wales Branch contributed £5,325. The money was raised by the issue of 600 debentures of £25 each, bearing interest at 10 per centum per annum. The issue was over-subscribed, the applications amounting to £17,000. It is expected that the new plant will be in full work by the end of the year, producing THE MEDICAL JOURNAL OF AUSTRALIA and doing other printing for the Branches and members and university bodies and scientific societies.

Financial Statements.

DR. GEORGE ARMSTRONG, the Acting Honorary Treasurer, presented the Financial Statement as shown on page 349. In moving its reception he pointed out that the year had commenced with a credit balance of £349 15s. 6d. and had closed with a credit balance of £1,380 12s. 11d. The motion was seconded by PROFESSOR F. P. SANDES and was carried.

Dr. Armstrong also presented the statement of the premises account. The net profit for the year was £1,438 16s. 7d. The mortgage stood at £6,750 and was being reduced at the rate of £1,000 a year. The debentures totalled £11,630.

Dr. Armstrong moved and Dr. F. BROWN CRAIG seconded the following motion which was carried with acclamation:

That the thanks of the meeting be conveyed to DR. A. M. GLEDEN and DR. F. W. HALL for their services as auditors.

President's Address.

DR. C. H. E. LAWES delivered an address (see page 327).

DR. ANDREW DAVIDSON said that it gave him much pleasure to move a hearty vote of thanks to Dr. Lawes for his extremely interesting address. Dr. Lawes had placed the position of the general practitioner before them

BRITISH MEDICAL ASSOCIATION—NEW SOUTH WALES BRANCH. Receipts and Expenditure for the Year ended December 31, 1923.

RECEIPTS.		EXPENDITURE.	
	£ s. d.		£ s. d.
Balance from 1922	349 15 6	British Medical Association ..	1,421 4 9
Subscriptions	6,144 13 3	THE MEDICAL JOURNAL OF AUSTRALIA	1,189 0 0
Late Dr. Litchfield Fund	5 5 6	Legal Expenses	3,250 0 0
Legal Expenses Contingency Fund	2,756 15 0	Late Dr. Litchfield Fund	5 5 6
Sales, Common Form of Agreement	18 11 5	Clerical Assistance	1,113 12 6
Interest	72 18 9	Library	124 19 9
Exchange on Cheques	19 6 6	Printing and Stationery	142 3 4
		Stamps, Telegrams <i>et cetera</i>	184 11 5
		Rent	300 0 0
		Less Contra	49 0 0
			251 0 0
		Federal Committee	124 14 0
		Telephone	22 15 10
		Travelling Expenses	3 16 3
		Exchange on Cheques	12 10 6
		Attendance at Meetings	27 9 7
		Cleaning Hall <i>et cetera</i>	26 0 0
		Australasian Medical Publishing Company, Limited (Links, <i>et cetera</i>)	5 10 5
		Repairs—Electric Light	20 16 6
		Interest	5 0 0
		Typewriter	26 0 0
		Sundries	15 7 3
		Balance, Petty Cash	14 15 5
		Balance as per Cash Book	1,380 12 11
			£9,367 5 11
	£9,367 5 11		

Examined and found correct,

A. MAITLAND GLEDEN
FRED. W. HALL

} Auditors.

GEORGE ARMSTRONG,
Acting Honorary Treasurer.

Honorary Treasurer.

Analytical Department.

HYPOL.

"HYPOL" is manufactured by Messrs. Felton, Grimwade and Company, Melbourne. It is an emulsion of cod liver oil containing hypophosphites. The process of manufacture of "Hypol" was observed by our inspector from the raw material to the finished bottled product. The inspection was carried out at a few hours' notice. The cod liver oil, free from all turbidity, is taken direct from twenty-five gallon tin-lined casks bearing a Norwegian label. The firm's analyst determines from time to time the density and the iodine and saponification values. In this way he can readily detect adulteration with vegetable oil or refined seal oil. The other ingredients of "Hypol," namely sodium and calcium hypophosphites, oil of almonds, oil of lemon and saccharine were inspected in the receptacles in which they had arrived at the factory. All bore names of highly respectable firms. Each of these chemical substances is checked by the firm's analyst. The intimate mixing is effected in an emulsifier which admits of perfect cleanliness. Our inspector was impressed with the fact that oxidation of the cod liver oil is avoided with considerable care. When once a cask has been opened up its contents are used as quickly as the manufacturing plant allows. In this way the contents do not remain exposed to the air for any length of time. In the emulsifier the process does not include the admixture of air. As the important vitamins of cod liver oil are highly susceptible to oxidation these precautions are to be commended.

When emulsification is complete "Hypol" is brought to a tin-lined copper and delivered to the bottles. The whole process is conducted with admirable and attractive cleanliness in the machinery, the containers, the general surroundings and the persons of the employees.

Analysis.

Analyses were made of a sample of "Hypol" obtained at the factory and of a second sample purchased in the open market. Both samples were well emulsified and showed no tendency to separate on standing. The results obtained on analysis are shown in the following table:

TABLE.

Constituents.	Sample obtained from Factory.	Sample obtained in Open Market.
Oil	47.3 %	47.4 %
Calcium hypophosphite ..	1.30%	1.10%
Sodium hypophosphite ..	0.62%	0.73%
Iodine value of oil .. .	170	169
Saponification value of oil	180	186
Refractive index of oil ..	1.4843 at 20° C.	1.4845 at 20° C.

These calculations were made by the gravimetric method. If the estimation had been by volume the amount of oil would be approximately 50%. This a very high ratio. In addition the emulsions contain some emulsifying agent and also a little flavouring and sweetening matter.

Conclusion.

The iodine number, saponification value and refractive index of the oil show that the emulsion is manufactured from a cod liver oil of excellent quality. The proprietors claim that "Hypol" contains a high percentage of pure cod liver oil and that it is suitable for use in the treatment of conditions in which the administration of cod liver oil is indicated. Their claims have been substantiated. The cleanliness and care used in the manufacture is beyond reproach and "Hypol" can be accepted as a thoroughly reliable product.

Obituary.

WILLIAM MACEWEN.

THE cabled news from London on March 24, 1924, of the death of Sir William Macewen was received by the medical profession throughout the Commonwealth with intense regret. His recent presence in Australia at the first Australasian Medical Congress (British Medical Association) as the official representative of the parent Association brought him into personal contact with members of the profession of all the States. His gentle and unassuming manner, his courtly bearing and his transparent sincerity endeared him to all with whom he came in contact and as a result a feeling of personal loss is associated with that which has been sustained by medical science in all its aspects.

William Macewen was born on June 22, 1848, and became an undergraduate in the Medical School of the University of Glasgow. Here he came under the influence of Lister and this association probably led Macewen to devote his life to surgery and doubtless laid the foundation for his subsequent extensive contributions to its art and practice. Lister had no more enthusiastic disciple and Macewen was one of those who did much to disseminate and establish Lister's teaching. Macewen's work was not confined to surgery, although his chief contributions to scientific knowledge were in this branch of medicine. Pathology and physiology claimed his attention to a considerable extent. It has been pointed out that Macewen's name is brought into prominence in some branch of practically every subject in the medical curriculum. He is probably best known through his contributions to osteology, the deformities of the lower limb and the surgery of the brain and spinal cord—a diversity of subjects demonstrative at once of his versatility and breadth of outlook. His own University of Glasgow recognized his worth and appointed him Regius Professor of Surgery in 1892 and he held this position till the end of his career. Other universities and scientific societies throughout the world vied with one another in doing him honour by admitting him to honorary degrees and membership. Among them were the Universities of Oxford, Dublin, Durham and Sydney and medical and surgical societies in Russia, Austria, Germany, France, Italy and America. The Royal College of Surgeons of England and of Ireland admitted him to honorary fellowship. He was a Fellow of the Royal Society. He had the honour of being appointed one of the surgeons of His Majesty the King in Scotland and was surgeon-general to the Royal Navy. He was President of the International Society of Surgery in 1923 and President of the British Medical Association in the same year. He received the honour of Knighthood in 1902 and was made a Companion of the Most Honourable Order of the Bath in 1917.

The passing of William Macewen, full of years and honour, will be regretted by every member of the medical profession in Australia and the memory of his career and attainments will act as an incentive for emulation to many. It is the happy lot and privilege of few men to achieve such well deserved distinction in the world of medicine.

RICHARD JONES.

WE regret to announce the death of Dr. Richard Jones which occurred on February 21, 1924, at Hawthorn, Victoria.

Born in Wexford, Ireland, sixty-three years ago, Richard Jones obtained his preliminary education at Barrington's School, Wexford. He subsequently studied medicine and in 1887 obtained his diplomas from the King and Queen's College of Physicians, Ireland, and the Royal College of Surgeons of Ireland. After serving for a term as house surgeon to a hospital in Dublin he took up private practice at Mumbles in Wales. He did not, however, stay here long, for he moved to Hawaii and for two years held the office of medical inspector of lepers to the Hawaiian Government. It was at this stage that he came to Australia and from 1891 to 1897 he practised in Hamilton-on-

Clyde in Tasmania. In 1897 he went to Eaglehawk, Victoria. He remained here for nine years and during that time served as honorary physician to the Bendigo Hospital. In 1907 he went to Dublin to pursue a course of post-graduate study. The following year he returned to Victoria and took over the practice of the late Dr. H. A. Embling in Hawthorn. Although he resided in Hawthorn, Richard Jones restricted his practice to consultation work in Collins Street. He specialized in genito-urinary diseases.

Reserved and retiring in disposition, but of great strength of character, Richard Jones was devoted to his professional work. His contributions to medical literature reflect a powerful personality. Among them may be mentioned a forcibly written pamphlet entitled "Small-pox and Vaccination" which he compiled for propaganda purposes at the request of the Board of Public Health of Victoria. The same convincing style is evidenced in his writings on the acclimatization of white people in the Northern Territory and on oral sepsis in relation to general medicine.

Death was for Richard Jones a release from a long and distressing illness which he bore with exemplary fortitude. A widow, one son and three daughters survive him and to them the sympathy of the medical profession will be extended.

THOMAS BORTHWICK.

THE death of Dr. Thomas Borthwick which occurred at Largs, South Australia, on March 11, 1924, was the cause of much regret amongst his friends and those who had been connected with him in his professional duties in Adelaide.

Thomas Borthwick was born sixty-four years ago in Scotland and received his medical education at Edinburgh University. He qualified as bachelor of medicine and master of surgery in 1881. In the early days of his career he took an interest in public health problems and in 1891 was admitted to the degree of doctor of medicine. The subject of his thesis was the demography of South Australia. He came to South Australia in 1883 and acted for several years as health officer of the municipalities of Kensington, Norwood and St. Peters. He subsequently became health officer for the East Torrens County Board of Health and in 1900 was appointed medical officer of health for the city of Adelaide. He held this position with credit to himself and benefit to the community until his retirement shortly before his death.

Thomas Borthwick was examiner in hygiene and lecturer in bacteriology at the University of Adelaide. He was for some time bacteriologist to the Adelaide Hospital and took an active part in the establishment of the bacteriology department at the Adelaide Children's Hospital. He was of a retiring disposition. He did his work unostentatiously and well, but when occasion demanded it he had the courage of his convictions and stood for what he believed to be right.

Dr. Gerald Hayward writes:

"To those who had the privilege of Dr. Borthwick's friendship, his loss will be keenly felt. He had a singularly reserved nature and was completely wrapped up in his duties as health officer, to which he devoted his whole attention and boundless energy. The only sport I ever knew him take any interest in was cricket and he was a frequent visitor at the big matches and he evidently derived much pleasure from watching the games.

He held very strong views regarding health matters and when the occasion demanded he never hesitated to express his opinion in the most emphatic and unequivocal manner and never shirked responsibility. During his last illness he commanded the respect of all of us by the heroic manner in which he bore his terrible affliction. I never heard him utter a word of complaint and he carried on his work to the last moment with unflinching fortitude. One of the last things which he did just before his operation when he was on the verge of starvation was to write

his annual report to the City Council and he said to me: 'Thank God that is finished; I have left everything in order and the sooner I die the better.'

"In his quiet, unostentatious manner he performed numerous acts of kindness to his less fortunate friends and colleagues and he will be sorely missed by all who knew him.

G. C. HAYWARD."

Adelaide,
March 25, 1924.

Hospitals.

PERTH HOSPITAL.

THE BOARD OF MANAGEMENT OF THE PERTH HOSPITAL, WESTERN AUSTRALIA, have issued the annual report for the year ended June 30, 1923. The report is a short document of forty-six pages and is a record of good work successfully carried out. It would appear that an effort is made to run the institution according to the funds which are available. Hospitals are proverbially overdrawn in their banking accounts and the Perth Hospital is no exception to this rule. The overdraft, however, at the end of the year under review stood at the comparatively low figure of £1,521.

Statistical.

During the year under review the number of in-patients treated was 4,206. During the previous year the number was 4,154. The number of patients remaining in the institution on June 30, 1923, was 313. The percentage mortality for the total patients treated was 7.5. It is impossible from the information given in the report to state whether this percentage mortality is correct or not. The correct method of estimating the percentage mortality is that which is laid down in the Registrar-General's formula. For the application of this formula it is necessary to know the number of deaths, the number of admissions and the number of discharges. Information in regard to these particulars is not given in the report. The average number of patients in the hospital *per diem* was 308 and the average duration of the stay of each patient was 24.9 days. The average cost per day for each in-patient, excluding expenditure on the out-patients' department and based upon extraordinary expenditure, was seven shillings and nine pence. This figure seems a very small one.

The expenditure for the year was the highest so far recorded. The average cost per patient per day has not increased. The increase has been in the amount of work performed. The total expenditure for the year was £50,766. Early in the year the question of increased pay and shorter hours for the wages staff was taken before the Arbitration Court. This resulted in an additional expenditure of £2,500 *per annum*.

Hospitals Bill.

The members of the board express regret that the Second Hospitals Bill was rejected by the Upper House. Had the bill been passed it would have been more beneficial to the Perth Hospital than to any other institution in the State. It is interesting to note that while the bill was before the House donations fell off to a considerable extent. In consequence of this a voluntary contributory scheme was placed before the Council of the Trades Hall in the hope that all unionists and wage earners would contribute as a result of official labour approval. The scheme has not yet been adopted.

X-Ray Department.

The sum of £750 has been spent on new apparatus for the X-ray department and a bedside unit has been donated to the hospital. The hope is expressed that a sum of money will be voted by the Government for the installation of a plant for the treatment of cancer by deep X-ray therapy.

Pathological Department.

For years past all pathological work in connexion with the institution has been carried out at the Government Pathological Laboratory. The honorary medical staff

advised the Board of Management to establish a pathological department at the hospital. It should not require much "mutual consideration and consultation" to undertake the establishment of a pathological department as an integral part of a hospital with three hundred beds. Dr. Sarah V. McConnell has been appointed pathologist.

Surgical Operations.

Appended to the report of the Chief Resident Medical Officer is a list of the surgical operations which have been undertaken at the institution during the year. We have frequently drawn attention to the uselessness of tabulated lists of operations such as are usually published in hospital reports. We have repeatedly pleaded for the collection of fuller details in this part of the report. In the report under consideration less information than usual is given of the nature of the operative procedures which have been undertaken.

Correspondence.

NATIONAL INSURANCE.

SIR: The question of national health insurance with medical benefits is at present occupying the attention of the Council of the British Medical Association in Australia. As one who has had personal experience of practice under the national insurance scheme in England, it is suggested that some of the common experiences that fell to my lot in the daily life of a panel doctor may be of interest to your readers.

I do not propose to deal with any broad outlines of policy or to discuss matters that are attended to by our Council or by the Australian Legislature, but simply to relate some of the day to day happenings in panel practice. I served for nearly a year as assistant to a firm of general practitioners in a country town of about fifteen thousand inhabitants and again for about six months as assistant to a country doctor whose rural practice had a radius of about ten miles and whose centre was a small village of some three hundred people. In each case the total income of the practice was considerably greater than it had been before national insurance came into being.

The panel doctor is supposed to have a list of insured patients whom he must attend when called upon to do so. Actually he gets no "list," but receives a card in an envelope for each patient on his list. This may mean up to three thousand cards.

The method of payment is as follows and is extremely difficult to check: Shortly after the beginning of each quarter he receives a sum on account, being a proportion of the money due to him. A few weeks later he receives a further proportion and at the end of the year a further sum as a final adjustment of his claim. He receives an additional sum for "mileage" for patients living more than a certain specified distance from his house. At the conclusion of each daily round he marks, as nearly as he can guess it, the distance he has travelled to see each individual insured patient and at the end of the year is paid a sum that is allotted to him as "mileage," but on what basis this mileage is calculated I was unable to discover.

He may be called to see a patient for the first time to find that, though the patient has been insured for a long time, he has not taken the trouble to be put on any doctor's list. The patient may or may not have been allotted to that particular doctor by the insurance committee, but at any rate the doctor's first dealing with him may be for a lengthy illness.

On one occasion I was sent by my chief to see a patient, who told me that he was not and had never been insured, though he was eligible to be insured. I attended him through a long illness. He subsequently became insured. My principal sent in his account to the patient. The insurance committee got hold of the account and informed my principal that it was satisfied that at the time of the illness the patient should have been entitled to insurance benefits, therefore they could not permit the account to be sent by my principal or to be paid by his patient.

From time to time an inspector, sometimes two or three inspectors together, inspect the doctor's surgery and waiting room and report on their suitability or otherwise and the doctor may be required to make specified alterations within a certain time or have his name struck off the panel.

The record cards are also inspected and the mode of keeping the entries criticized. Some or any of the cards may be removed by the inspector. Later they may be returned from the county insurance office where, it is to be presumed, they have been open to the inspection of lay clerks in the office. Periodically some or all of the cards have to be sent to the county insurance office, where they are open to similar lay inspection.

The form and manner of keeping the records on the cards is frequently changed.

When an insured patient who normally resides in another part of the country visits the district of a panel doctor and requires the services of the local doctor a form of communication passes between (i.) the local doctor, (ii.) his county insurance office, (iii.) the patient's regular doctor, (iv.) and the patient's regular county office. Some adjustment of fees is made between the two doctors by the two county offices concerned.

A panel doctor does not operate. Should he do so he is not allowed to charge a fee and he must provide an anaesthetist at his own expense.

Should the cost of a panel doctor's prescriptions amount to more than the average of the cost of the prescriptions of the other panel doctors in his county, he is called upon to explain the reason for this excessive cost, is frequently made to pay this cost himself and is sometimes heavily fined in addition.

The doctor, when giving the patient a prescription must write it in triplicate, signing his full name and address to each copy. Carbon leaf triplicates are allowed. One copy is kept by the doctor and the other two are given to the patient. No "repeat" prescriptions are allowed. The prescription must be written in full and in triplicate at each repetition of the prescription.

When the doctor employs servants he must insure them. He must affix stamps for his own proportion of the insurance to the servant's card and he must see that the servant also affixes his own stamps to the card. The servant, however, expects the doctor to pay for both sets of stamps.

Yours, etc.,

JOSEPH LOVE.

47, Balaclava Road, East St. Kilda,
March 18, 1924.

VENEREAL DISEASE.

SIR: When venereal clinics were established at public hospitals, they were primarily intended for those who were unable to afford private treatment and who were under the Act obliged to have medical attention for their complaint. At present there are men attending these clinics who are well able to afford moderate fees for private treatment, men who dress well and who in very many cases are single and earning at least a basic wage. These persons I contend are not fit patients although hospitals have to take them. Free treatment for this class of patient invites carelessness in sexual matters and is very undesirable. I have had in my hospital clinic patients who have returned with an admitted fresh infection within two weeks of discharge for a former infection. It costs them nothing, so why should they worry!

In venereal diseases it a well-known fact that the patient's pocket comes into the scheme of treatment and when it is touched he takes greater care of himself both during and after treatment. The treatment of venereal diseases is definitely a business and cannot reasonably be expected to be satisfactorily handled in any other way. Indiscriminate charity is harmful, in fact is a tacit consent to the mode of life of the patient.

Yours, etc.,

J. COOPER BOOTH.

171, Macquarie Street, Sydney,
March 13, 1924.

LOCAL ANÆSTHESIA IN OPHTHALMIC SURGERY.

SIR: I have for some little time past been using "Phenolaine" in ophthalmic practice as a local anæsthetic and an antiseptic. I am writing to draw the attention of brother oculists to its efficiency. It is a fluid and is made up for local anæsthetic purposes in the strength of two minims to the ounce. In the quantities used it is apparently non-toxic, it keeps well and it is certainly a most efficient anæsthetic. The destruction of in-growing lashes by electrolysis, usually so painful, becomes a simple and painless affair. The anæsthesia lasts for a considerable time. I have had no objectionable consequences from its use except where it has been injected near acutely inflamed tissues. I have had some success with it in advanced cases of trachoma by infiltrating the lid with it in the manner recommended by Nesfield who brought the drug under notice. It also lends itself well to employment in sub-conjunctival injections.

Yours, etc.,

JAMES W. BARRETT.

105, Collins Street, Melbourne,
March 21, 1924.

Books Received.

- THE EXAMINATION OF PATIENTS, by Nellis B. Foster, M.D., 1923. Philadelphia and London: W. B. Saunders Company; Melbourne: James Little; Demy 8vo., pp. 253, illustrated.
- CLINICAL DIAGNOSIS BY LABORATORY METHODS, by James Campbell Todd, M.D.; Fifth Edition, Revised, Enlarged and Reset; 1923. Philadelphia and London: W. B. Saunders Company; Melbourne: James Little; Demy 8vo., pp. 762, with 325 illustrations, including 29 in colour.
- GYNECOLOGY, by William P. Graves, A.B., M.D., F.A.C.S.; Third Edition, Thoroughly Revised; 1923. Philadelphia and London: W. B. Saunders Company; Melbourne: James Little; Royal 8vo., pp. 936, illustrated.
- ANÆSTHESIA IN DENTAL SURGERY, by the late Thomas D. Luke, M.D., F.R.C.S. (Edin.); Edited by J. Stuart Ross, M.B., F.R.C.S. (Edin.), with a Chapter upon Local and Regional Anæsthesia, by Major W. T. Finlayson, O.B.E., L.R.C.P., L.R.C.S. (Edin.), L.D.S. (Edin.); Fifth Edition; 1924. London: William Heinemann (Medical Books) Limited; Crown 8vo., pp. 252, with 45 illustrations. Price: 10s. 6d. net.
- LECTURES ON ENDOCRINOLOGY, by Walter Timme, M.D.; 1924. New York: Paul B. Hoeber; Post 8vo., pp. 123, with 27 illustrations. Price: \$1.50.
- FOOD FOR THE DIABETIC, by Mary Pascoe Huddleson, with an Introduction by Nellis Barnes Foster, M.D.; 1923. New York: The Macmillan Company; Sydney: Angus and Robertson; Crown 8vo., pp. 87.

Medical Appointments.

DR. ALBERT CURTIS (B.M.A.) has been appointed, temporarily, Medical Superintendent of the Hospital for the Insane and Receiving House, at Ballarat, Victoria.

THE undermentioned have been appointed Public Vaccinators in Victoria: DR. DOROTHEA V. CHURCH (B.M.A.), at Warracknabeal; DR. A. P. DERHAM (B.M.A.), at the Children's Depot, Royal Park.

THE undermentioned have been authorized by the Board of Health of New South Wales as Inspectors under the *Cattle Slaughtering and Diseased Animals and Meat Act*, 1902: DR. G. M. B. HALES (B.M.A.), at Finley; DR. F. M. PURCHAS (B.M.A.), at Young.

Medical Appointments Vacant, etc..

For announcements of medical appointments vacant, assistants, *locum tenentes* sought, etc., see "Advertiser," page xviii.

BALMAIN AND DISTRICT HOSPITAL, SYDNEY: Medical Vacancies.

ROYAL NORTH SHORE HOSPITAL OF SYDNEY, ST. LEONARDS: Honorary Assistant Surgeon to Diseases of the Ear, Nose and Throat.

VICTORIAN EYE AND EAR HOSPITAL, MELBOURNE: Two Resident Surgeons.

Medical Appointments: Important Notice.

MEDICAL practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429, Strand, London, W.C..

BRANCH.	APPOINTMENTS.
NEW SOUTH WALES: Honorary Secretary, 30 - 34, Elizabeth Street, Sydney	Australian Natives' Association Ashfield and District Friendly Societies' Dispensary Balmain United Friendly Society's Dispensary Friendly Society Lodges at Casino Leichhardt and Petersham Dispensary Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney Marrickville United Friendly Societies' Dispensary North Sydney United Friendly Societies People's Prudential Benefit Society Phoenix Mutual Provident Society
VICTORIA: Honorary Secretary, Medical Society Hall, East Melbourne	All Institutes or Medical Dispensaries Australian Prudential Association Proprietary, Limited Mutual National Provident Club National Provident Association
QUEENSLAND: Honorary Secretary, B.M.A. Building, Adelaide Street, Brisbane	Brisbane United Friendly Society Institute Stannary Hills Hospital
SOUTH AUSTRALIA: Honorary Secretary, 12, North Terrace, Adelaide	Contract Practice Appointments at Renmark Contract Practice Appointments in South Australia
WESTERN AUSTRALIA: Honorary Secretary, Saint George's Terrace, Perth	All Contract Practice Appointments in Western Australia
NEW ZEALAND (WELLINGTON DIVISION): Honorary Secretary, Wellington	Friendly Society Lodges, Wellington, New Zealand

Diary for the Month.

- APR. 9.—Tasmanian Branch, B.M.A.: Branch.
APR. 9.—Melbourne Pediatric Society.
APR. 10.—Brisbane Hospital for Sick Children: Clinical Meeting.
APR. 11.—Queensland Branch, B.M.A.: Council.
APR. 11.—South Australian Branch, B.M.A.: Council.
APR. 16.—Victorian Branch, B.M.A.: Council.
APR. 16.—Western Australian Branch, B.M.A.: Branch.
APR. 24.—South Australian Branch, B.M.A.: Branch.
APR. 25.—Queensland Branch, B.M.A.: Council.
MAY 2.—Queensland Branch, B.M.A.: Branch.
MAY 7.—Victorian Branch, B.M.A.: Branch.
MAY 8.—Brisbane Hospital for Sick Children: Clinical Meeting.
MAY 9.—Queensland Branch, B.M.A.: Council.
MAY 9.—South Australian Branch, B.M.A.: Council.
MAY 14.—Tasmanian Branch, B.M.A.: Branch.

Editorial Notices.

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